

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01595 CERTIFICATE OF DEATH 01541

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>8 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY <b>HAMPSHIRE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>PURGITSVILLE</b> d. STREET ADDRESS <b>25-3</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SCOTT</b> Middle <b>R.</b> Last <b>ALT</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>15</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-24-1889</b> 9. AGE (in years last birthday) <b>76</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>FRANK ALT</b>		14. MOTHER'S MAIDEN NAME <b>MARY YOKUM</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>232-26-1688</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 DUE TO <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>very advanced</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Onset</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-7-</b> 19 <b>66</b> to <b>2-15-</b> 19 <b>66</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>2-14-</b> 19 <b>66</b> , and that death occurred at <b>6:15 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. W. F. Williams M.D.</b>		22b. DATE SIGNED <b>2/15/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE ST.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 18, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Alt cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Brushy Run, W. Va.</b>	
24. FUNERAL DIRECTOR <b>Arlyn S. Arnold,</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>	
ADDRESS <b>Petersburg, W. Va.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01253

01253

ALLICANY

TURKITSVILLE

8 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

SCOTT

ALT

FEBRUARY 12

WHITE

MALE

11-24-1983

WEST VIRGINIA

HARRY YOKUM

FRANK ALD

WEST VIRGINIA

MEMORIAL HOSPITAL, CUMBERLAND, MD

DR. W. F. WILLIAMS

122 S. CENTRE ST.

W. VA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01596					01542									
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE									
ALLEGANY					MARYLAND									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 221 VIRGINIA AVE.									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last FREDERICK W ARMBRUSTER					Month Day Year FEBRUARY 22 19 66									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-14-1885		9. AGE (In years last birthday) 80 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		10b. KIND OF BUSINESS OR INDUSTRY Own & Retail		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.			12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME GEORGE W. ARMBRUSTER					14. MOTHER'S MAIDEN NAME DORA LEAR									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction - multiple</i> 4201 DUE TO <i>previous infarction 6 weeks + 6 years ago</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>hypertension c. renal failure; prostatic</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>15 years</i>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>1973</i> to <i>2/22</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>2/21</i> 19 <i>66</i> , and that death occurred at <i>5:45A.M.</i> from the causes and on the date stated above.														
22a. SIGNATURE <i>Dr. S. G. Weisman</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2/25/66</i>							
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN					22d. ADDRESS 59 GREENE ST.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 25, 1966		23c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery			23d. LOCATION (City, town or county) (State) Deer Park, Md.							
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR FEB 28 1966					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

01542

01528

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

41 DAYS

CUMBERLAND

221 VIRGINIA AVE.

MEMORIAL HOSPITAL

ARMSTRONG FEBRUARY 22 1966

FEDERAL

10-14-1862

MALE WHITE

CUMBERLAND, MD.

DORA LEAH

GEORGE W. ARMSTRONG

MEMORIAL HOSPITAL, CUMBERLAND, MD.

22 GREEN ST.

DR. S. C. WEISMAN



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01597

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01543

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 HRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>41 CRESAP DRIVE, BOWLING GREEN</b>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR DAY</b>		4. DATE OF DEATH <b>2/3/66</b>	
5. SEX <b>MALE</b>		6. COLOR OF RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/13/88</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Filtration Employ.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Fibres</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Luke, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Benjamin Arnold</b>		14. MOTHER'S MAIDEN NAME <b>Mollie (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>217-10-4674</b>	
17. INFORMANT <b>Mrs. Frank Noonan</b> Address <b>41 Cresap Dr. Bowling Green, Md.</b>		PATIENT'S CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-3-</b> , 19 <b>66</b> , to <b>2-3-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2-3-</b> , 19 <b>66</b> , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <b>L Brings</b>		22b. DATE SIGNED <b>2-4-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. L. BRINGS</b>		22d. ADDRESS <b>57 Greene St. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/6/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Eckhart, Maryland</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b> ADDRESS <b>Cumberland, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

11543

01553

RECEIVED

RECEIVED

RECEIVED

ALL ORDERS DRIVE, BOSTON, MASS.

MASSACHUSETTS

2/1/68

APRIL 12

DAY

FROM US

11

7/23/68

WINTER

WINTER

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01598					01544				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
ALLEGANY MARYLAND					MARYLAND ALLEGANY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
FROSTBURG			3 WEEKS		FROSTBURG			01-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MINERS HOSPITAL					158 E. COLLEGE AVENUE				
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH		Month Day Year		
GEORGE			R. BARRY		FEBRUARY 15,		19 66		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	DEC. 19, 1919		46 yrs.		Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
BOBBIN CLEANER			CELANESE CORP.		MARYLAND		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
JAMES J. BARRY					CLARA R. SMITH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFIRMANT		Address		
			215-12-2369		MRS. DOLORES BARRY, FROSTBURG, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pancreatitis</i>									
260X DUE TO (b) <i>Uncontrollable Diabetes Mellitus</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>March</i> , 19 <i>66</i> , to <i>2/15</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>2/15</i> , 19 <i>66</i> , and that death occurred at <i>2:30</i> P.M. from the causes and on the date stated above.									
22a. SIGNATURE			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)				
<i>John B. Davis</i>			<i>2/17/66</i>		JOHN B. DAVIS, M.D.				
22d. ADDRESS			22e. REC'D BY REGISTRAR						
BROADWAY, FROSTBURG, MD.			FEB 18 1966						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
BURIAL			FEB. 18 '66		SUNSET MEMORIAL PARK		CUMBERLAND, MD.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
JOSEPH R. DURST, SR., FROSTBURG, MD.			FEB 18 1966		<i>Charles Judge</i>				

1950

U.S. DEPARTMENT OF HEALTH

1950

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF PUBLIC HEALTH  
DIVISION OF VITAL STATISTICS  
WASHINGTON, D. C.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM (5)  
5M 1/65

01599

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01545

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D. O. A. Memorial Hosp.</u>		d. STREET ADDRESS <u>86 Meadow View Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lelia</u> Middle <u>Franklin</u> Last <u>Bennear</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>9,</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 12, 1906</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Martin Hager</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No,</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Calvin L. Lease</u>		Address <u>Cresaptown, Md.</u> <u>86 Meadow View Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>4201</u> CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>CORONARY SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>  <u>====</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb. 9, 1966</u> <u>Md.</u> Address (Street, city, town, or county) <u>Rt. # 9 Cumberland,</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/12/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	23d. LOCATION (City, town or county) (State) <u>Cumberland, Maryland</u>
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>	
ADDRESS <u>Cumberland, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01545

01545

MEDICAL EXAMINER - DISTRICT OF COLUMBIA

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

01600

STATE OF MARYLAND  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01546

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b>			c. LENGTH OF STAY IN 1b <b>2 years</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Foundry Row</b>			d. STREET ADDRESS <b>Foundry Row</b>		
3. NAME OF DECEASED (Type or print) <b>WILBUR S. BLANDOW</b>			4. DATE OF DEATH <b>February 17, 1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1898</b>		9. AGE (In years last birthday) <b>67 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Station</b>		11. BIRTHPLACE (State or foreign country) <b>Chicago, Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>William Blandow</b>		
14. MOTHER'S MAIDEN NAME <b>Carolina Pape</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>324-18-2349</b>			17. INFORMANT <b>Mrs. Wilbur S. Blandow, Foundry Row, Mt. Savage, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>ASPHYXIATION</b> <b>1621</b> DUE TO <b>HEMORRHAGE FROM BRONCHOGENIC CARCINOMA --</b> Conditions, if any, which gave rise to immediate cause (b) <b>HEMORRHAGE FROM BRONCHOGENIC CARCINOMA --</b> (e), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Feb. 17, 1966</b> DATE SIGNED Address (Street, city, town, or county) <b>Cumberland, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 20, 1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park Frostburg, Maryland</b>	
22d. LOCATION (City, town, or country) <b>Frostburg, Md.</b>		23. FUNERAL DIRECTOR Name (Type) <b>Walter M. Luer</b> Address <b>Hafer Funeral Home, 60 West Main St.</b>			
24a. REC'D BY REGISTRAR <b>FEB 23 1966</b>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

01546

RECEIVED

1950

THE AIR  
MAIL

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a series of lines or a list.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01601					01547					
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CRESAPTOWN</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>20 WINCHESTER ROAD</b>					
3. NAME OF DECEASED (Type or print) <b>ROBERT J. BONIECE</b>			First Middle Last		4. DATE OF DEATH <b>FEB. 1, 1966</b>		Day Month Year			
5. SEX <b>MALE</b>		6. CDLDR DR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-12-1919</b>		9. AGE (In years last birthday) <b>47</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SR. TECH WRITER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>MISSILE</b>			11. BIRTHPLACE (County & State, or foreign country) <b>WILKINSBURG, PA.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM BONIECE</b>					14. MOTHER'S MAIDEN NAME <b>EMMA MUTZ</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>297 09 8160</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BACTEREMIC SHOCK -</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PNEUMONIA</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CIRRHOSSIS OF LIVER, MYOCARDIAL HYPERTROPHY AND DILATATION</b>										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>2/1, 1966</b> , that (I) (we) last saw the deceased alive on <b>2/1, 1966</b> , and that death occurred at <b>10:37 A.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>DR. THOMAS E. LUSBY</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/2/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. THOMAS E. LUSBY</b>					22d. ADDRESS <b>932 NATIONAL HIGHWAY, LA VALE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>			23b. DATE THEREOF <b>FEB. 5, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CREMATORY</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON, D. C.</b>			
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>					ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR <b>FEB 7 1966</b>			
					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

01501

01501

ALLEGANY

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CUMBERLAND

CRESTATION

MEMORIAL HOSPITAL

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ROBERT

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MALE WHITE

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WILLIAM BONCE

2000 HITS

MEMORIAL HOSPITAL - CUMBERLAND, MD.

BACTEREMIC SHOCK -

PNEUMONIA

DIAGNOSIS OF LIVER, MYOCARDIAL HYPERTROPHY AND DILATION

10:37 A.M.

DR. THOMAS E. LUSBY

932 NATIONAL HIGHWAY, LA VAY, MO.

1-2-1962

1-2-1962

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>						c. LENGTH OF STAY IN 1b <b>25 DAYS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						d. STREET ADDRESS <b>721 Lafayette Ave.</b>					
3. NAME OF DECEASED (Type or print) <b>HERBERT L. BOONE</b>						4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>4</b> Year <b>19 66</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-15-1901</b>		9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist Helper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA - Rio</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN BOONE</b>						14. MOTHER'S MAIDEN NAME <b>MARY DAVY</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>214-05-6683</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OCebral Edema</b> <b>4221</b> DUE TO (b) <b>Lobar Pneumonia</b> DUE TO (c) <b>Congestive Heart Failure due to Atherosclerosis</b> underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>25 days</b> <b>14 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Y. Infection</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> , 19 <b>Feb</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Feb 4</b> , 19 <b>66</b> , and that death occurred at <b>1:13 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>DR. G. O. HIMMELWRIGHT</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/5/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. G. O. HIMMELWRIGHT</b>						22d. ADDRESS <b>133 VIRGINIA AVE.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Feb. 8, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Poland Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Rio, West Virginia</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

11548

11548

ALLIANCE

MARYLAND

ALLEGANY

CUMBERLAND

25 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

FEBRUARY 1944

BOONE

HEBERT

7-12-1944

WEST VIRGINIA

W. S. A.

JOHN BOON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

11548

133 VIRGINIA AVE.

DR. D. D. HINCHES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01603

01549

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN lb <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>200 1/2 Avirett Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Russell</u> Middle <u>Willmer</u> Last <u>Brant</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>19</u> Year <u>1966</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept. 9, 1904</u>
<b>9. AGE</b> (In years last birthday) <u>61</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Millworker</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Cumberland, Md.</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>Howard Brant</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Ada Rice</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or (unknown)) (If yes, give year or dates of service) <u>No</u>	
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>Cumberland, Md.</u> <u>Mrs. Alice Brant, 200 1/2 Avirett Ave.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (b) <u>Emphysema</u> (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>years</u> <u>years</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>January 19, 1966</u> , to <u>Feb. 19, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 18, 1966</u> and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Dr. Blane M. Schindler</u> NAME (Type)		<b>22b. DATE SIGNED</b> <u>Feb. 21, 1966</u>	<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Blane M. Schindler</u>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb. 21, 1966</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hillcrest Burial Park</u>
<b>23d. LOCATION</b> (City, town or county) <u>Cumberland, Maryland</u>		<b>23e. (State)</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. Wayne George, Cumberland, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 24 1966</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>25c. DATE</b>	

VR A15 (4)  
15M 9/60

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01540

FEB 24 1966

FEB 24 1966

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01604

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1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flintstone</u>		c. LENGTH OF STAY IN lb <u>01-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <u>Flintstone Route #2</u>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Jackson</u> Last <u>Browning</u>		4. DATE OF DEATH Month <u>February</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1903</u>
9. AGE (In years last birthday) <u>62 yrs.</u>		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian of Girl Scout Camp</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ephraim Browning</u>		14. MOTHER'S MAIDEN NAME <u>Etta Hamilton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-5812</u>	
17. INFORMANT <u>Mrs. Irene Browning</u>		Address <u>Route #2 Flintstone, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>STATUS ASTHMATICUS</u> 241X DUE TO (b) <u>(BRONCHIAL ASTHMA)</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>-----</u>		INTERVAL BETWEEN ONSET AND DEATH MINUTES	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarellic</u> M.D.		22. DATE SIGNED February 4, 1966	
EXAMINER'S NAME (Type) <u>Benedict Skitarellic, M.D.</u>		Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/7/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	23d. LOCATION (City, town or county) (State) <u>Cumberland Maryland</u>
24. FUNERAL DIRECTOR <u>Ruth E. Silcox</u>		25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>	
ADDRESS <u>Cumberland Maryland 21502</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>BB ALLEGANY</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>COMBERLAND</b>						c. LENGTH OF STAY IN 1b <b>XXX 11 DAYS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSP.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ALDON BURNARD BUCKLEY</b>						4. DATE OF DEATH <b>2-8-66</b> 19 <b>19</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-22-1889</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>W.VA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
13. FATHER'S NAME <b>GEORGE BUCKLEY</b>						14. MOTHER'S MAIDEN NAME <b>Catherine Weatherholt</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-12-8880</b>		17. INFORMANT <b>DAUGHTER &amp; CHART</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> <b>1992</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma of bone and liver</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus, Pulmonary Fibrosis, Aortic Sclerosis</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>June 29, 1965</b> to <b>Feb. 8, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb. 7, 1966</b> , and that death occurred at <b>3:30M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Samuel M. Jacobson</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <b>A.M.</b>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 8, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel M. Jacobson, M. D.</b>						22d. ADDRESS <b>50 Pershing St., Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Glebe West Virginia</b>			
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>						ADDRESS <b>Cumberland Maryland 21502</b>		25a. REC'D BY REGISTRAR <b>FEB 11 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01606

## CERTIFICATE OF DEATH

01552

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15 Forest Drive</u>		d. STREET ADDRESS <u>15 Forest Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Bernard F. Coyle</u>		4. DATE OF DEATH <u>Feb. 7</u> 19 <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17 1896</u> 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furniture Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>Jeanesville Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Coyle</u>		14. MOTHER'S MAIDEN NAME <u>Mary Smyth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Bernard F. Coyle Jr. La Vale Md.</u>	
17. INFORMANT <u>Bernard F. Coyle Jr. La Vale Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia &amp; infection; dehydration.</u> 602X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute &amp; chronic pyelonephritis</u> DUE TO (c) <u>&amp; bilateral stagnant calculi.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>yr.</u>	
PART II. OTHERS SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe oropharyngitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/7</u> , 19 <u>66</u> , to <u>2/7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> , 19 <u>66</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Walter N. Sumner</u>		22b. DATE SIGNED <u>2/8/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/10/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter &amp; Paul Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland Md.</u>	
24. FUNERAL DIRECTOR <u>Louis Stein Inc. Camb. Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>FEB 11 1966</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**01607**

## CERTIFICATE OF DEATH

**01553**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>McCoole</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hill Top</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole</u> d. STREET ADDRESS <u>Hill Top</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Albert Sale Creasy</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>Feb. 26 19 66</u>					
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>B. DATE OF BIRTH</b> <u>Aug. 29th, 1886</u>	<b>9. AGE</b> (In years last birthday) <u>79</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Rt. Carman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>B &amp; O RR</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Montvale, Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Charles A. Creasy</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Wiggington</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>705 09 7518</u>		<b>17. INFORMANT</b> Address <u>Edw. Creasy, McCoole, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> 4221 DUE TO (b) <u>Arteriosclerotic cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cerebral arterial insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 month</u> <u>5 years</u> <u>5 years</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1B.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.  19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify</b> that (I) <u>Dr. Coffman</u> attended the deceased from <u>July 1965</u> to <u>2/26 1966</u> , that (I) <u>we</u> last saw the deceased alive on <u>2/26 1966</u> , and that death occurred at <u>3 a.m.</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Harry F. Coffman, M.D.</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>2/28/66</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Harry F. Coffman, M.D.</u>				<b>22d. ADDRESS</b> <u>126 E. Armstrong Street Keyser, W. Va.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3-1-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Potomac Valley Memo. Pk.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Keyser, W. Va.</u>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Albin H. Kotruck</u>				<b>ADDRESS</b> <u>Keyser, W. Va.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 2 1966</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01608

01554

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>17 Fifth Street</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>17 Fifth Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Randolph</b> Last <b>Davy</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 2, 1909</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	9. AGE (In years last birthday) <b>56</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Bloomington, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wright Davy</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Jewell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>War II</b>		16. SOCIAL SECURITY NO. <b>705-12-4748</b>	
17. INFORMANT <b>Mrs. Margaret Cook, Cumberland, Md. Friend</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, Left</b> 4201 DUE TO <b>Coronary Thrombosis</b> (b) DUE TO <b>Coronary Sclerosis</b> (c) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>  <b>"</b>  <b>---</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		22. DATE SIGNED <b>February 5, 1966</b> <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 10, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Va.</b>
24. FUNERAL DIRECTOR <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
25a. REC'D BY REGISTRAR <b>EB 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01609 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01555

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rt. # 6 Cumberland,</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rt. # 6 Cumberland,</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Along U. S. Rt. # 220 nr. Rawlings</i>				d. STREET ADDRESS <i>Rawlings</i> <i>Along U. S. Rt. # 220 nr</i>			
3. NAME OF DECEASED (Type or print) First <i>Calvin</i> Middle <i>Russell</i> Last <i>Deremer</i>				4. DATE OF DEATH Month <i>Feb.</i> Day <i>10,</i> Year <i>1966</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 26, 1891</i>	9. AGE (In years last birthday) <i>74</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None, Disabled Veteran</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Cresaptown, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Frederick Deremer</i>				14. MOTHER'S MAIDEN NAME <i>Mollie Dawson</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes,</i>		16. SOCIAL SECURITY NO. <i>W. W. # 1</i>		17. INFORMANT <i>Mrs. Mary Deremer</i>		Address <i>Rt. # 6 Cumberland, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>4201</i> DUE TO (b) <i>Coronary sclerosis</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> -----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Disabled W. W. # 1 Veteran gassed while in service</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>February 10, 1966</i>	
EXAMINER'S NAME (Type) <i>Benedict Skitarelic, M.D.</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Cumberland, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2/13/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Burial Park</i>		23d. LOCATION (City, town or county) (State) <i>Cumberland, Maryland</i>			
24. FUNERAL DIRECTOR <i>H. Wayne George</i>				ADDRESS <i>Cumberland, Md.</i>		25a. REC'D BY REGISTRAR <i>FEB 14 1966</i>	
				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Midland</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Midland</b>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address)						<b>d. STREET ADDRESS</b>			<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print)			First <b>John</b> Middle <b>Devlin</b> Last <b>Devlin</b>			<b>4. DATE OF DEATH</b>			Month <b>February</b> Day <b>11</b> Year <b>19 66</b>				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 13, 1892</b>		<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Lonaconing, Maryland</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				
<b>13. FATHER'S NAME</b> <b>Henry Devlin</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Woods</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>John J. Devlin</b>			<b>Address</b> <b>Midland, Md.</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] <b>"Son"</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Sudden</b>			
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a) Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis, Coronary Insufficiency</b> DUE TO <b>Myocardial Fibrosis</b> (c)													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Diabetes Mellitus</b>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH</b> <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21. I certify that (I) (this hospital) attended the deceased from April, 19 62, to Feb. 11, 19 66, that (I) (we) last saw the deceased alive on Feb. 9, 19 66, and that death occurred at 5:30 A.M. from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> 						<b>22b. DATE SIGNED</b> <b>2/12/66</b>			<b>22c. PHYSICIAN'S NAME</b> (Type) <b>SAMUEL M. JACOBSON, M. D.</b>			<b>22d. ADDRESS</b> <b>50 Pershing St., Cumberland, Md. 21502</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>2/14/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Michaels Cemetery</b>			<b>23d. LOCATION</b> (City, town or county) (State) <b>Frostburg, Md.</b>					
<b>24. FUNERAL DIRECTOR</b> <b>George Eichhorn</b>				<b>Address</b> <b>Lonaconing, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>FEB 14 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 			

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ellerslie</b>			c. LENGTH OF STAY IN 1b <b>60 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ellerslie</b>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) <b>Rachel</b>			First <b>May</b>		Middle <b>De</b>		Last <b>Vore</b>		4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1884</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>1</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Bedford Co., Pa.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Witt</b>					14. MOTHER'S MAIDEN NAME <b>Catherine Clites</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-48-4188</b>		17. INFORMANT <b>Mrs. Dorothy Bohn, Ellerslie, Md.</b>				Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Renal Insufficiency</b> <b>4200</b> DUE TO (b) <b>Senile A.S. Generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Chronic A.S.H. with Hypertension</b>									INTERVAL BETWEEN ONSET AND DEATH <b>20 days</b> <b>20 yrs.</b> <b>20 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>Mass Lesion - Right lobe having X-ray appearance of Metastasis</b>									WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>October</b> , 19 <b>65</b> , to <b>Feb. 11</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Jan 21</b> , 19 <b>66</b> , and that death occurred at <b>4:45</b> PM, from the causes and on the date stated above.									
22a. SIGNATURE <b>John A. Topper</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-12-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>John A. Topper M.D.</b>					22d. ADDRESS <b>Hyndman, Pa.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 14, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Porter Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hyndman, Pa. RD#1</b>			
24. FUNERAL DIRECTOR <b>Howard S. Ziegler</b>					ADDRESS <b>Hyndman, Pa.</b>		25a. REC'D BY REGISTRAR <b>FEB 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01612					CERTIFICATE OF DEATH					01558				
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>					c. LENGTH OF STAY IN lb <b>12 days</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sacred Heart Hospital</b>					d. STREET ADDRESS <b>202 East Main Street</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Margaret Ada Donahue</b>					4. DATE OF DEATH <b>February 4 1966</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-23-12</b>		9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				
13. FATHER'S NAME <b>William Lucas</b>					14. MOTHER'S MAIDEN NAME <b>Annie Winner</b>					12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. <b>217-10-6421</b>					17. INFORMANT <b>Pt. Chart</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease</b> DUE TO (c) <b>Congestive Heart Failure</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 yr.</b> <b>3 mo.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cardiomegaly and Hepatomegaly</b>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>None 19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>January 24, 1966</b> , to <b>February 4, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb. 4, 1966</b> , and that death occurred at <b>3:45 PM</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>James P. Hallinan M.D.</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>2-6-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>James P. Hallinan M.D.</b>					22d. ADDRESS <b>140 Bedford St., Cumberland, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>Feb. 7 '66</b>					23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>				
					23d. LOCATION (City, town or county) (State) <b>Frostburg, Md.</b>									
24. FUNERAL DIRECTOR <b>Joseph R. Durst, Sr., Frostburg, Md.</b>					25a. REC'D BY REGISTRAR <b>FEB 10 1966</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



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William James  
Born 1-23-72  
Died 1-23-72  
Cause of Death  
Heart Failure  
Rheumatic Heart Disease  
Coronary Occlusion

1 day  
3 yr.  
3 mo.

Endocarditis and Myocarditis

None

None

January 23, 1972

Feb. 1, 1972

1-23-72

110 Bedford St., Cambridge, MA.

James E. Sullivan M.D.

100. 1 1/2

George H. Smith, M.D., Providence, R.I.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**01613**

## CERTIFICATE OF DEATH

**01559**

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach to carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> c. LENGTH OF STAY IN 1b <b>2 WEEKS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> d. STREET ADDRESS <b>244 EAST MAIN STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CARRIE</b> Middle <b>DUCKWORTH</b> Last <b>DUCKWORTH</b> <b>4. DATE OF DEATH</b> Month <b>FEBRUARY</b> Day <b>20</b> Year <b>19 66</b>				<b>5. SEX</b> <b>FEMALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>MAY 19, 1891</b> <b>9. AGE (in years last birthday)</b> <b>74</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>OWN HOME</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>LONACONING, MARYLAND</b> <b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>JAMES NICHOLS</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>GERTRUDE TREZISE</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> Address <b>FROSTBURG, MD.</b> <b>MRS. ELLEN BURKETT, 244 EAST MAIN ST.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b> DUE TO <b>Hypertensive</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO <b>10 yrs?</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>DIABETES</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> Wife <input type="checkbox"/> Not Wife <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>FROSTBURG</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>2/9</b> , 19 <b>66</b> to <b>2/20</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>2/20</b> , 19 <b>66</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Martin M. Rothstein</b> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b>		<b>22b. DATE SIGNED</b> <b>2/22/66</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>MARTIN M. ROTHSTEIN, M.D.</b>		<b>48 BROADWAY, FROSTBURG, MD.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>FEB. 23, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>LAUREL HILL CEMETERY</b>			
<b>23d. LOCATION</b> (City, town or county) <b>MOSCOW</b> (State) <b>MARYLAND</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HAFFER FUNERAL HOME, 60 W. MAIN ST.</b>					
<b>25a. REC'D BY REGISTRAR</b> <b>FEB 28 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01614

01560

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rawlings,</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rawlings,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Along U. S. Rt. # 220</u>		d. STREET ADDRESS <u>Along U. S. Rt. # 220</u>	
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>---</u> Last <u>Evans</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1883</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife,</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Moorefield, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John A. Rumer</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Clarence W. Walters, Rawlings, Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No,</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Clarence W. Walters, Rawlings, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>-----</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		22. DATE SIGNED <u>February 1, 1966</u>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/3/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Restlawn Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>	
ADDRESS <u>Cumberland, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

07500

00010

Dec. 17, 1932

1932-1933

*Handwritten signature*

1932-1933

1932-1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01615						01561					
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>9HRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg, MD.</b> d. STREET ADDRESS <b>Parkersburg Rd. RT. 2, BOX 178</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>HERMAN</b> First <b>Adolph</b> Middle <b>FILSINGER</b> Last			4. DATE OF DEATH <b>FEBRUARY 26,</b> Month <b>19 66</b> Day Year								
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-3-1891</b>		9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>HERMAN FILSINGER</b>						14. MOTHER'S MAIDEN NAME <b>LOUISA HAUSDRATH</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-01-3597</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissecting Aortic Aneurysm</b> <b>451X</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>No</b> INTERVAL BETWEEN ONSET AND DEATH <b>9 hrs</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , 19 to <b>Feb</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Feb 25</b> , 19 <b>66</b> , and that death occurred at <b>4:15 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>[Signature]</b> 22c. PHYSICIAN'S NAME (Type) <b>DR. G.O. HIMMELWRIGHT</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/27/66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/1/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Eckhart, Md.</b>			
24. FUNERAL DIRECTOR <b>H. Wayne George</b> Cumberland, Md.						25a. REC'D BY REGISTRAR <b>MAR 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

01501

01501

ALLEGANY

GUNBELAND

MEMORIAL HOSPITAL

HEPMA

FILSINGER

MALE WHITE

12-3-1901

HEPMA

MARYLAND

LOUISA HANSEN

HEPMA FILSINGER

MEMORIAL HOSPITAL, GUNBELAND, MD.

1-1-1901

133 VIRGINIA AVE.

DR. G.O. HINCHL. RIGHT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN b <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>226½ N. LEE STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>Helen</b> Last <b>FINK</b>						4. DATE OF DEATH Month <b>FEB.</b> Day <b>25</b> Year <b>19 66</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-9-1888</b>		9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months   Days   Hours   Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND Allegany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>WILLIAM BOYD</b>						14. MOTHER'S MAIDEN NAME <b>LOUISA DAVIS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-16-2763</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of body of</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>pancreas with widespread</b> (c) <b>metastases</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH <b>At least 6 mos</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1-6-1966</b> to <b>2-25-1966</b> , that (I) (we) last saw the deceased alive on <b>2-25-1966</b> , and that death occurred at <b>12:25 p.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>W. F. Williams</b>						22b. DATE SIGNED <b>2-26-66</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>			
22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR <b>H. Wayne George</b>						ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

2

gp

11268

01316

ALLEGANY

ALLEGANY

CUMBERLAND

CUMBERLAND

2 DAYS

337 N. 1ST STREET

MEMORIAL HOSPITAL

77 FEB. 22. 1900

CHINA

8-0-1886

FEMALE WHITE

HELVAND ALLEGANY U. S. A.

HELVAND

HELVAND

LOUISE DAVIS

WILLIAM BOYD

MEMORIAL HOSPITAL - CUMBERLAND, MD.

11-1-1900

DR. W. F. WILLIAMS

122 S. CENTRE ST., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01617

01563

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELEY</b>		d. STREET ADDRESS <b>RT 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OSCAR</b> Middle <b>WILLIAM</b> Last <b>FLANAGAN</b>		4. DATE OF DEATH Month <b>2</b> Day <b>10</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>2-27-97</b>
9. AGE (In years last birthday) yrs. <b>68</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iron Industry</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>EVENWOOD, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John (William Flanagan)</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Mc Bee</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes War 1</b>		16. SOCIAL SECURITY NO. <b>705-12-6585</b>	
17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) <b>chronic hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 year</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-9-1966</b> , to <b>2-10-1966</b> , that (I) (we) last saw the deceased alive on <b>2-10-1966</b> , and that death occurred at <b>11</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Lewis Drings</b>		22b. DATE SIGNED <b>2-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lewis Drings, M.D.</b>		22d. ADDRESS <b>57 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 14, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 18 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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John (William) ...

...

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

01618

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01564

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harpersville-Rural Lonaconing</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harpersville-Rural-Lonaconing</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>JEAN M. GEORGE</b>		4. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/21/1921</b>
9. AGE (In years lost birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Gilmore, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Martin</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Livingston</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-07-6762</b>	
17. INFORMANT <b>Russell George, Lonaconing, MD.</b>		Address <b>(Husband)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GUNSHOT OF CHEST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(SELF INFLICTED)</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		22. DATE SIGNED <b>2/28/1966</b>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, Cumberland, MD.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Charles Judge</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/3/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Frostburg, MD.</b>
24. FUNERAL DIRECTOR <b>George Eichhorn</b>		25a. REC'D BY REGISTRAR <b>MAR 3 1966</b>	
ADDRESS <b>Lonaconing, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01619 CERTIFICATE OF DEATH 01565

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>RAWLINGS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>Nr. U. S. Rt. # 220</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>Bertha</b> Last <b>GORDON</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>27</b> Year <b>1966</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 21, 1890</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND Allegany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM LEASE (D)</b>				14. MOTHER'S MAIDEN NAME <b>Margaret MC KENZIE LEASE (D)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Elsie E. Haan Rt. # 5 Cumb. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebrovascular Accident, Rt.</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 25, 1966</b> , to <b>Feb. 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb. 26, 1966</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Calvin Y. Hadidian</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>CALVIN Y. HADIDIAN</b>				22d. ADDRESS <b>ALGONQUIN HOTEL, CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/3/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Biertown Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Nr. Rawlings, Maryland</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>				25a. REC'D BY REGISTRAR <b>MAR 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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STATE OF TEXAS

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THE UNIVERSITY OF TEXAS

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June 17, 1932

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U. S. DEPARTMENT OF AGRICULTURE

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01566

**FOR STATE  
HEALTH DEPT. M**

**01620**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CUMBERLAND</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>200X DECATUR ST. CUMBERLAND</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOMEWOOD ADDITION</b>						d. STREET ADDRESS <b>200 DECATUR ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>HAST</b> Last				4. DATE OF DEATH Month <b>FEB.</b> Day <b>19</b> Year <b>1966</b>							
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 14, 1904</b>		9. AGE (In years last birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMP.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>ALBERT HAST</b>						14. MOTHER'S MAIDEN NAME <b>ELLA REUSCHLIEN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>ROBERT HAST, JR. BALTIMORE, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>BENED ICT SKITARELIC, M.D.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>February 19, 1966</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>FEB. 22, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. LUKES CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>			
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b> ADDRESS <b>CUMBERLAND, MD.</b>						25a. REC'D BY REGISTRAR <b>FEB 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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01630

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01621					CERTIFICATE OF DEATH					01567				
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>					c. LENGTH OF STAY IN 1b <b>Cumberland</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>611 Kent Ave.</b>										d. STREET ADDRESS <b>611 Kent Ave.</b>				
3. NAME OF DECEASED (Type or print) <b>George F Hazelwood, Sr.</b>					4. DATE OF DEATH <b>February 21 1966</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 26, 1887</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>					11. BIRTHPLACE (County & State, or foreign country) <b>England</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>Fred Hazelwood</b>					14. MOTHER'S MAIDEN NAME <b>Ellen Haynes</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>—</b>					17. INFORMANT <b>Mrs. Margery Hazelwood, 611 Kent Ave.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Colonometasis</b> <b>1530</b> DUE TO <b>adenocarcinoma Colon, junction caecum with ascending Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>with resection 30 June 1965</b> (c)										INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>A.S. Cardiovascular disease 5 years.</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)					20g. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>19 December 1949</b> to <b>20 February 1966</b> , that (I) (we) last saw the deceased alive on <b>20 February 1966</b> , and that death occurred at <b>3:30</b> M, from the causes and on the date stated above.														
22a. SIGNATURE <b>W. A. Van Ormer</b>					22b. DATE SIGNED <b>22 Feb. 1966</b>									
22c. PHYSICIAN'S NAME (Type) <b>W. Alfred Van Ormer, M. D.</b>					22d. ADDRESS <b>122 S. Centre St., Cumberland, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>Feb. 23, 1966</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>				
23d. LOCATION (City, town or county) (State) <b>Allegany County MD.</b>					24. FUNERAL DIRECTOR <b>Louis Stein Inc.</b>					25a. REC'D BY REGISTRAR <b>55B 24 1966</b>				
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>														

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2003-07-10

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21. *Chrysomelidae*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12  
FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01622

01568

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> , <u>01-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. O. A. Memorial Hosp.</u>		d. STREET ADDRESS <u>30 Roberts St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>Headley</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17, 1966</u>
9. AGE (in years last birthday) <u>1</u> yrs. <u>11</u> Months <u>11</u> Days <u></u> Hours <u></u> Min.		10. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (infant)</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>None (infant)</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles W. Headley</u>		14. MOTHER'S MAIDEN NAME <u>Laura J. Clites</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Charles W. Headley</u>		Address <u>30 Roberts St. Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>7541</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Patent Ductus Arteriosus</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>February 28, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/3/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01584

01585

10

Jan. 17, 1955

Jan. 17, 1955

Jan. 17, 1955

Jan. 17, 1955

Jan. 17, 1955

Jan. 17, 1955

Jan. 17, 1955

Jan. 17, 1955

Jan. 17, 1955

Jan. 17, 1955

Jan. 17, 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their names remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within any event, within 72 hours after death.

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01623

01569

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>20 DAYS</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				d. STREET ADDRESS <b>RT. #2, WILLIAMS ROAD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <b>GEORGE P HINKLE</b>				4. DATE OF DEATH <b>FEB. 28 1966</b>				5. SEX <b>MALE</b>				6. COLOR OR RACE <b>WHITE</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>Mar. 12, 1889</b>				9. AGE (In years last birthday) <b>76 yrs.</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Surveyor</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Allegany Co., Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Edward Milton Hinkle</b>				14. MOTHER'S MAIDEN NAME <b>Hattie L. Twigg</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-10-2072</b>				17. INFORMANT <b>Mrs. Charlotte Deneen, Hinkle Road, Cumberland</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Congestive Heart Failure</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from <b>2-8 1966</b> , to <b>2-28 1966</b> , that (I) (we) last saw the deceased alive on <b>2-28 1966</b> , and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above.				22a. SIGNATURE <b>William P. James</b>				22b. DATE SIGNED <b>3/1/66</b>				22c. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM P. JAMES</b>				22d. ADDRESS <b>441 N. CENTER ST. CUMBERLAND, MD.</b>				22e. REC'D BY REGISTRAR <b>Charles Judge</b>				22f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>March 3, 1966</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hermon Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Near Cumberland, Md.</b>				24. FUNERAL DIRECTOR <b>John J. Hafer</b>				25a. ADDRESS <b>230 Balto Ave., Cumberland, Md.</b>				25b. REC'D BY REGISTRAR <b>MAR 4 1966</b>				25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>															

01589

01589

ALLEANY

ALLEANY

CUMBERLAND

CUMBERLAND

50 DAYS

ST. W. WILLIAMS ROAD

MEMORIAL HOSPITAL

FEB. 18 1960

HINKLE

GEORGE

MAR. 12, 1959

MALE WHITE

Alleany Co., Maryland

Registered Nurse

Maternity I. White

Maternity I. White

200-10-201 Mrs. Charlotte B. Hinkle, Cumberland

DR. WILLIAM P. JAMES

March 3, 1960 Dr. William P. James, Cumberland, Md.

200-10-201 Mrs. Charlotte B. Hinkle, Cumberland, Md.

TO HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01624					01570				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>ALLEGANY</b>					a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					b. COUNTY <b>ALLEGANY</b>				
c. LENGTH OF STAY IN 1b <b>5 DAYS</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>RT.#1, BOX 321</b>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>JANE B HOTCHKISS</b>					4. DATE OF DEATH Month Day Year <b>22 2/6/1966 19</b>				
5. SEX <b>FEMALE</b>		6. COLOR OF RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 18, 1884</b>		9. AGE (In years last birthday) <b>81 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>SCOTLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>SAMUEL BROWN</b>					14. MOTHER'S MAIDEN NAME <b>JANE MC KENNON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage, massive, with rt. hemiplegia.</b> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio-sclerotic cardiovascular disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>1 Feb.</b> , 19 <b>66</b> , to <b>6 Feb.</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>6 Feb.</b> , 19 <b>66</b> , and that death occurred <b>6:12 PM</b> from the causes and on the date stated above. 22a. SIGNATURE <b>W. Alfred Van Ormer</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>WILLIAM A. VAN ORMER</b> 22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b> 22b. DATE SIGNED <b>FEB 10 1966</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>2/9/1966</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b> 23d. LOCATION (City, town or county) (State) <b>Frostburg, Md.</b> 24. FUNERAL DIRECTOR <b>GEORGE EICHHORN</b> ADDRESS <b>LONACONING, MD.</b> 25a. REC'D BY REGISTRAR <b>FEB 10 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

01624

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

JANE

FEMALE WHITE

JONES WIFE

SYNUEL BROWN

NO

LONG

MARYLAND

FROSTBURG

2 DAYS

RT. 1, BOX 351

NOTCHWISS

OCT. 15, 1964

SCOTLAND

JANE MC KENNA

ALLEGANY

01520

CENTRAL

MEMORIAL HOSPITAL, CUMBERLAND, MD.

WILLIAM A. VAN ORMER - 123 S. CENTRE ST., CUMBERLAND, MD.

Memorial Park

JOHN BISHOP

LEBANON, PA.

Lebanon, Pa.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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01625

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
DR. LEY  
CERTIFICATE OF DEATH

01571

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>RT. #1, BOX 490</b>	
3. NAME OF DECEASED (Type or print) <b>ELMER C. HOVATTER</b>		4. DATE OF DEATH <b>FEBRUARY 2 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-1907</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CELANESE CORP. OF AMERICA</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WEST VIRGINIA</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HOVATTER</b>		14. MOTHER'S MAIDEN NAME <b>NORA E. HOVATTER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-5139</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>1621</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/31</b> , 19 <b>66</b> to <b>2/2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/1</b> , 19 <b>66</b> , and that death occurred at <b>4:22 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Leo H. Ley</b>		22b. DATE SIGNED <b>2-7-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. LEO H. LEY</b>		22d. ADDRESS <b>456 N. CENTRE STREET, CUMBERLAND MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 4, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Madley Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Near Hyndman, Penna.</b>	
24. FUNERAL DIRECTOR <b>John J. Hafer</b>		25a. REC'D BY REGISTRAR <b>230 Balto Ave., Cumberland, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Hafer</b>		DATE <b>FEB 7 1966</b>	

01832

DR. LEY

01521

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

DAY

FROSTBURG

MEMORIAL HOSPITAL

RT. #1, BOX 400

ELMER

HOVATTER

FEBRUARY 2 50

MALE WHITE

3-17-1907

28

DELANESE CORP. OF AMERICA

WEST VIRGINIA

U.S.A.

HOVATTER

MORA C. HOVATTER

MEMORIAL HOSPITAL - CUMBERLAND, MD.

217-10-2132

NO

DR. LEO H. LEY

MD.

410 E. CENTRE STREET, CUMBERLAND

Feb. 4, 1966

Madley Cemetery

Near Hyndman, Penn.

230 Balco Ave., Cumberland, MD

1966

TO HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01626

01572

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>17 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>			d. STREET ADDRESS <b>7 VIRGINIA AVE.</b>			
3. NAME OF DECEASED (Type or print) <b>KIMBERLY JANE HOWSER</b>			4. DATE OF DEATH <b>FEB. 13 19 66</b>			
5. SEX <b>FEMALE</b>			6. COLOR OR RACE <b>WHITE</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>1/28/66</b>			
9. AGE (In years last birthday) <b>17</b>			10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>DAVID R. HOWSER</b>			14. MOTHER'S MAIDEN NAME <b>JANE E. HUNT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meconium Peritonitis.</b> <b>7680</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <b>17 days.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1/28/66</b> to <b>Feb 13 1966</b> , that (I) (we) last saw the deceased alive on <b>2/13 1966</b> , and that death occurred at <b>4.50 PM</b> from the causes and on the date stated above.						
22a. SIGNATURE <b>J. W. Eliason</b>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>DR. H. ELIASON</b>			22d. ADDRESS <b>203 GREENE ST. CUMBERLAND, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 14, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		
23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>		24. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>				
25a. REC'D BY REGISTRAR <b>FEB 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

01578

01578

ALLEGANY

MARY ANN

CUMBERLAND, MD.

17 DAYS

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

7 VIRGINIA AVE.

FEB. 13

JANE HOWSER

IV

1753/66

FEMALE WHITE

U.S.A.

CUMBERLAND, MD.

JANE E. HUNT

DAVID B. HOWSER

MEMORIAL HOSPITAL, CUMBERLAND, MD.

303 GREENE ST. CUMBERLAND, MD.

DR. H. ELIASON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01627						01573					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <b>Allegany</b>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			a. STATE <b>Maryland</b>			b. COUNTY <b>Allegany</b>		
c. LENGTH OF STAY IN 1b <b>2 mos., 18 das.</b>			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sylvan Retreat</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			d. STREET ADDRESS <b>Bedford Road</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First <b>Benjamin</b>			Middle <b>Frank</b>			Last <b>Huffman</b>		
4. DATE OF DEATH			Month <b>Feb.</b>			Day <b>1</b>			Year <b>1966</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 26, 1881</b>		9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days	
										IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jobie Huffman</b>						14. MOTHER'S MAIDEN NAME <b>Sidney Bennett</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Mrs. Goldie Crone</b> <b>Route #3 Bedford Rd Cumberland, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332x</b> DUE TO (b) <b>Arterio Sclerosis, Cerebral &amp; General</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>17 1/2 Senile &amp; psychotic tendencies</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>11 A.M.</b>		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 13, 1965</b> to <b>Feb. 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb. 1, 1966</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>L. B. Mathews</b>						ATTENDING PHYS. <input type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>L. B. Mathews, M.D.</b>						22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2/3/66</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Davis</b>			23d. LOCATION (City, town or county) (State) <b>Davis W.Va.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wayne O. Spiggle</b>						ADDRESS <b>Davis, W.Va.</b>			25a. REC'D BY REGISTRAR <b>FEB 7 1966</b>		
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

01351

01351

RECEIVED

NOV 19 1951

NOV 19 1951

NOV 19 1951

NOV 19 1951

NOV 19 1951

NOV 19 1951

NOV 19 1951

NOV 19 1951

NOV 19 1951

NOV 19 1951



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
01628					01574				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>39 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> d. STREET ADDRESS <b>233 WINNERS LANE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>KATHLEEN</b> Last <b>JACKSON</b>					4. DATE OF DEATH Month <b>FEB.</b> Day <b>5</b> Year <b>19 66</b>				
5. SEX <b>FEMALE</b>					6. COLOR OR RACE <b>COLORED</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>AUG. 31, 1919</b>				
9. AGE (In years last birthday) <b>46</b> yrs.					IF UNDER 1 YEAR Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) <b>PENNA</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>CHARLES WORKMAN</b>					14. MOTHER'S MAIDEN NAME <b>NETTIE HALL</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. <b>NONE</b>				
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary failure due to massive metastases</b> 170X DUE TO (b) <b>Chest wall &amp; liver metastases</b> DUE TO (c) <b>Carcinoma - right breast</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b> <b>1 year</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>Dec</b> , 19 <b>65</b> , to <b>Feb 5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Feb 5</b> , 19 <b>66</b> , and that death occurred at <b>7:40 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Thomas F. Lewis</b>									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. LEWIS</b>									
22d. ADDRESS <b>500 GREENE ST., CUMBERLAND, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>									
23b. DATE THEREOF <b>FEB. 8 '66</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL PARK</b>									
23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>									
24. FUNERAL DIRECTOR <b>J. R. DURST, SR., FROSTBURG, MD.</b>									
25a. REC'D BY REGISTRAR <b>FEB 10 1966</b>									
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

01828

ALLEGANY

CUMBERLAND

FEMALE-COLORED

CHARLES WORKMAN

THOMAS F. LEWIS

33 DAYS

FROSTBURG

NATHAN JACOBSON

AUG. 31, 1919

PENNA

METTIC HALL

7:40 AM

500 GREENE ST., CUMBERLAND, MD.

533 WINNERS LANE

FEB. 2, 1920

U.S.A.

ALLEGANY

MARYLAND

01574

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>47 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>937 Maryland Avenue</u>					d. STREET ADDRESS <u>937 Maryland Avenue</u>				
3. NAME OF DECEASED (Type or print) <u>Lester Leo Jewell</u>					4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14, 1901</u>		9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Strausburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Toliver Jewell</u>					14. MOTHER'S MAIDEN NAME <u>Mary Ellen Higgs</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>705-09-9754</u>		17. INFORMANT Address <u>Mrs. Esther Jewell, Cumberland, Md. Wife</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>1621</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>16 mon</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 16, 1964</u> to <u>Feb. 24, 1966</u> that (I) (we) last saw the deceased alive on <u>Jan. 24, 1966</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>W.C. Spigale</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u>2-26-66</u>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. W.C. Spigale, M.D.</u>					22d. ADDRESS <u>126 N. Smallwood St., Cumberland, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 27, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>			23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>		
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>MAR 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

01575

01580

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>6 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>RT. #2, BOX 685</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>GEORGE W. KEEFER</b>			4. DATE OF DEATH <b>FEBRUARY 19 1966</b>			5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>5-25-1888</b>			9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA-FAYETTE</b>		12. CITIZEN OF WHAT COUNTRY? <b>CO. U.S.A.</b>	
13. FATHER'S NAME <b>JOHN KEEFER</b>			14. MOTHER'S NAME <b>SUSAN HOOVER</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 1</b>			
16. SOCIAL SECURITY NO. <b>163-12-6741</b>			17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO (b) <b>Cerebral Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>2/15/66</b> , 19 to <b>2/19/66</b> , 19, that (I) (we) last saw the deceased alive on <b>2/15/66</b> , 19, and that death occurred at <b>4:07 A.M.</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>DR. R. J. WILLIAMS</b>			22b. DATE SIGNED <b>2/19/66</b>			22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>			
22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						
23b. DATE THEREOF <b>Feb. 22, 1966</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Connellsville, Penna</b>			
24. FUNERAL DIRECTOR <b>John J. Hafer</b>			25a. REC'D BY REGISTRAR <b>Feb 21 1966</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

01576

01630

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

3 DAYS

CUMBERLAND

RT. 12, BOX 65

MEMORIAL HOSPITAL

FEBRUARY 19 1977

KEPT

W.

GEORGE

WHITE

MALE

PENNSYLVANIA FARETTE CO. U.S.A.

BETWEEN CARPENTERS

SURAN HOOVER

JOHN KEEFER

103-12-071 MEMORIAL HOSPITAL - CUMBERLAND, MD.

WM I

Yes

8:02 A.M.

122 S. CENTRE ST., CUMBERLAND, MD.

DR. F. J. WILLIAMS

Cumbersville, Tenn

Vol. 22, 1966 W. Olive Cemetery

1211

230 - Illinois Ave. Cumberland, MD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<div style="display: flex; justify-content: space-between;"> <span>01631</span> <span>CERTIFICATE OF DEATH</span> <span>01577</span> </div>											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WILEY FORD</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NORA</b>			First Middle Last <b>V. KLINE</b>			4. DATE OF DEATH Month Day Year <b>FEB. 7 19 66</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 8-1909</b>		9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Mln. <b>IF UNDER 24 HRS.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND Cumberland</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>OLIVER OWENS</b>						14. MOTHER'S MAIDEN NAME <b>JENNIE TROUTMAN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Arrest</b> <b>431X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Pulmonary Embolism</b> DUE TO (c) <b>Acute &amp; Chronic Myocarditis - Coronary artery Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>11 minutes</b> <b>3 days</b> <b>2 years</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic Mellitus - Anterior pituitary gland disease</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> <b>29.59 P.M. Feb.</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Feb 7</b> 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>DR. G. OVERTON HIMMELWRIGHT</b>						22b. DATE SIGNED <b>2/8/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>DR. G. OVERTON HIMMELWRIGHT</b>						22d. ADDRESS <b>133 VIRGINIA AVE. CUMB. MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Feb. 11, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>DATE FEB 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

01577

01577

WEST VIRGINIA

WILEY FORD

3 DAYS

MEMORIAL HOSPITAL

1944

WHITE

W.

MOBA

JULY 3-1900

REMALE WHITE

NATURAL

OLIVER OWENS

JENNIE THOMPSON

MEMORIAL HOSPITAL

DR. G. OVERTON RIMMELWRIGHT 133 VIRGINIA AVE. CUM. MO.

FEB 1 1955

DR. G. OVERTON RIMMELWRIGHT, M.D.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

01579

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE OF DECEASED LIVED, IF INSTITUTION: RESIDENCE BEFORE ADMISSION a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>30 yrs. 36 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart</b>		d. STREET ADDRESS <b>Box 753</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Virginia</b> Last <b>Krnaya</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/29/14</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Isaac Parker</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Grant</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-07-3775</b>	
17. INFORMANT <b>Patients chart- Geo. Krnaya, Box 753</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hemorrhoidal arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-12-</b> , 19 <b>66</b> , to <b>2-18-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2-18</b> , 19 <b>66</b> , and that death occurred at <b>2-18</b> , 19 <b>66</b> , and that death occurred at <b>2-18</b> , 19 <b>66</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Lewis Brings</b>		22b. DATE SIGNED <b>2-19-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lewis Brings</b>		22d. ADDRESS <b>57 Greene St., Cumberland, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 21, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>	
24. FUNERAL DIRECTOR <b>John F. Hafer</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

01570

STATE OF TEXAS

01570

County of ...

County of ...

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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01633

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01580

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b <b>2 Weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>511 Cumberland Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Adam</b> Last <b>Kuhley</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Railroad Conductor</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>	
13. FATHER'S NAME <b>John A. Kuhley</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Lyon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>714-03-0046</b>	
17. INFORMANT <b>Mrs. Ethel Dorn</b>		Address <b>511 Cumberland St Cumberland, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC MYOCARDITIS</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>February 13, 1966</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/15/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lake Park Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Youngstown Ohio</b>
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland 21502</b>	25a. REC'D BY REGISTRAR <b>FEB 15 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

01520

01520

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "REPORT" and "DATE" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>01634</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>01581</span> </div> <div style="text-align: center;">             DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>51 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						d. STREET ADDRESS <b>311 ARCH STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print)			First <b>GLADYS</b>		Middle <b>IRENE</b>		Last <b>LAM</b>		<b>4. DATE OF DEATH</b> Month <b>FEBRUARY</b> Day <b>4</b> Year <b>19 66</b>		
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>5-11-1905</b>		<b>9. AGE (In years last birthday)</b> <b>60</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>TEACHER- ALLEG.CO.</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>BD. OF EDUCATION</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>CUMBERLAND, MD.</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>CHARLES H. LAM</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>LELIA C. BENNETT</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Sarcomatous</i> <b>1991</b> DUE TO (b) <i>Ligo sarcoma right chest wall</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 yr</b> <b>5 yrs</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>July</i> , 19 <i>62</i> , <b>to</b> <i>Feb 4</i> , 19 <i>66</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>Feb. 3</i> 19 <i>66</i> , <b>and that death occurred at</b> <i>5:45 A.M.</i> <b>from</b> <i>the</i> <b>causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <i>Donald B. Grove</i>						<b>22b. DATE SIGNED</b> <b>Feb 4, 1966</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>DR. DONALD B. GROVE</b>		<b>22d. ADDRESS</b> <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>Feb. 6, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>E. U. B. Cemetery</b>			<b>23d. LOCATION (City, town or county) (State)</b> <b>Shenandoah, Virginia</b>		
<b>24. FUNERAL DIRECTOR</b> <b>James F. Scarpelli, Cumberland, Md.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>FEB 8 1966</b>					
						<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>					

MEDICAL CERTIFICATION

01333

DR. GROVE

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

GLADYS

IRENE

LIN

FEBRUARY 4 68

FEMALE WHITE

2-11-1902

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TEACHER ALLEG. CO. OF EDUCATION CUMBERLAND, MD. U.S.A.

CHARLES H. LIN

LOUISA C. BENNETT

MEMORIAL HOSPITAL CUMBERLAND, MD.

DR. DONALD B. GROVE

122 S. CENTRE ST. CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01635					01582						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>ALLEGANY</b>					a. STATE <b>MARYLAND</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					b. COUNTY <b>ALLEGANY</b>						
c. LENGTH OF STAY IN 1b <b>5 DAYS</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>311 ARCH ST.</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First <b>LELIA</b> Middle <b>C.</b> Last <b>LAM</b>			4. DATE OF DEATH			Month <b>FEBRUARY</b> Day <b>21</b> Year <b>19 66</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-13-1880</b>		9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA-Shenandoah</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>GEORGE BENNETT</b>						14. MOTHER'S MAIDEN NAME <b>MARY RINICA</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thromboses Left Femoral Vein</b> <b>4222</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>non Malignant Ruptured Aneurysm</b> DUE TO (c) <b>Myocarditis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>3 wks</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 20</b> , 1965 to <b>Feb. 21</b> , 1966, that (I) (we) last saw the deceased alive on <b>Feb 20</b> 1966, and that death occurred at <b>5:40 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Clay Durrett</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/21/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. CLAY DURRETT</b>						22d. ADDRESS <b>236 VIRGINIA AVE.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Feb. 24, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>E.U.B. Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Shenandoah, Virginia</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

01588

01588

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

5 DAYS

CUMBERLAND

311 ARCH ST.

MEMORIAL HOSPITAL

FEBRUARY 21 / 68

LAM

LELIA

12-13-1968

FEMALE WHITE

VIRGINIA - U.S.A.

MARY CLINIC

GEORGE BENNETT

MEMORIAL HOSPITAL, CUMBERLAND, MD.

2:00AM

336 VIRGINIA AVE.

DR. CLAY DUPRETT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

BP

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01636					01583						
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>3 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> f. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>122 W. OLDTOWN RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARL E. LANDIS</b>			4. DATE OF DEATH Month Day Year <b>FEB. 28 19 66</b>		9. AGE (In years last birthday) <b>59</b> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 28, 1906</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND-CUMBERLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		13. FATHER'S NAME <b>RUBEN LANDIS</b>				14. MOTHER'S MAIDEN NAME <b>CLARA LOGUE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 65</b> to <b>3:10 p.m. Feb. 19 66</b> that (I) <b>no</b> last saw the deceased alive on <b>Feb 28 19 66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.										22b. DATE SIGNED <b>3/2/66</b>	
22a. SIGNATURE <b>DR. G. OVERTON HIMMELWRIGHT</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <b>DR. G. OVERTON HIMMELWRIGHT</b>					
22d. ADDRESS <b>133 VIRGINIA AVE. CUMBERLAND, MD</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 3, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>					
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>DATE MAR 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>					

01583

01583

ALLEGANY

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ALLEGANY

CUMBERLAND

3 DAYS

CUMBERLAND

122 W. CLARK ST.

MEMORIAL HOSPITAL

28

188

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E.

CARL

AUGUST 28, 1906

MALE WHITE

W.C.A.

MARYLAND

CLARA FLORE

ROSEN LANE

MEMORIAL HOSPITAL

X

3:10 P.M. Feb

26

X

DR. F. OVERTON HIMMELWRIGHT

133 ALBERTA AVE. CHICAGO, ILL.

2, 1906

admission



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01637

01584

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 75 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 217 Dexter Place		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle J. Last Langley		4. DATE OF DEATH Month Feb. Day 2 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1890	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-05-7744		17. INFORMANT Address Miss Margaret O'Donnell, Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) CORONARY SCLEROSIS c) OUE TO		19. INTERVAL BETWEEN ONSET AND DEATH HOURS --			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
ACTUAL SIGNATURE Benedict Skitarelic		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 2-4-1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		Address (Street, city, town, or county) Rt. 9 Cumberland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 5, 1966		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City, town or county) Cumberland, Md.		23e. REC'D BY REGISTRAR FEB 8 1966		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS			

48010

15010

RECEIVED  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT. (M)

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
01638									
01585									
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>65 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			d. STREET ADDRESS <u>913 Zihlman Way</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>301 Holland Street</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Herman</u> Last <u>Lilya</u>			4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 11, 1890</u>		9. AGE (In years last birthday) <u>75 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Glass Worker</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank H. Lilya</u>					14. MOTHER'S MAIDEN NAME <u>Beda Eck</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT <u>Miss Ellen Lilya</u>		Address <u>913 Zihlman Way</u> <u>Cumberland, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4201</u> OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> OUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <u>8.m.</u> p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>			M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			<u>February 28, 1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosehill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland Maryland</u>		
24. FUNERAL DIRECTOR <u>Ruth E. Silcox</u> <u>Cumberland Maryland</u>					25a. REC'D BY REGISTRAR <u>MAR 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

01585

01585

10

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01639					01586				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>ALLEGANY</b>					a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					b. COUNTY <b>ALLEGANY</b>				
c. LENGTH OF STAY IN 1b <b>6 Hours</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>					d. STREET ADDRESS <b>114 INDEPENDENCE STREET</b>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First <b>WALTER</b> Middle <b>NMI</b> Last <b>LOWE</b>					Month <b>FEB</b> Day <b>23</b> Year <b>1966</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-06-07</b>		9. AGE (In years last birthday) <b>58 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baggage Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Station</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Allegany Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13. FATHER'S NAME <b>George Lowe</b>				14. MOTHER'S MAIDEN NAME <b>Georgia Taylor</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW 2 220-10-4797</b>		17. INFORMANT <b>Bessie Wheeler</b> Address <b>114 Independence St Cumberland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> (c) <b>arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>months</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 1960</b> to <b>Feb 23 1966</b> that (I) (we) last saw the deceased alive on <b>Feb 23 1966</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>DR. B. SCHINDLER</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-24-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. B. SCHINDLER</b>						22d. ADDRESS <b>43 GREENE ST CUMBERLAND, MARYLAND.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Feb. 26, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>		
24. FUNERAL DIRECTOR <b>John J. Hafer</b>				ADDRESS <b>230 Balto Ave., Cumberland Md</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01380

01380

US DEPARTMENT OF JUSTICE

US DEPARTMENT OF JUSTICE

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Allegany Co., Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01640		MARYLAND STATE DEPARTMENT OF HEALTH	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND		DR. BRODELL	
CERTIFICATE OF DEATH		01587	
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>132 POTOMAC STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SHELLI</b> Middle <b>LYNN</b> Last <b>MALONE</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>1</b> Year <b>19 66</b>	
5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>7-29-1965</b> 9. AGE (in years last birthday) <b>6</b> yrs. Months <b>6</b> Days <b>6</b> Hours <b>1</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>none</b> 11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HAROLD W. MALONE</b>		14. MOTHER'S MAIDEN NAME <b>DONA JEAN PAYNE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b> 17. INFORMANT <b>Mrs. Donna Malone, Cumberland, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute fulminating interstitial pneumonia</b> DUE TO (c) <b>Viremia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b> <b>18 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> , 19 <b>66</b> , to <b>2/1</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/1</b> , 19 <b>66</b> , and that death occurred at <b>11:50 P.M.</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>DR. ROBERT D. BRODELL</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>2/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. ROBERT D. BRODELL</b>		22d. ADDRESS <b>500 GREENE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 4, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b> ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 7 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01551

DR. BROOK J.

ALLEGANY

ALLEGANY

CUMBERLAND

L DAY

CUMBERLAND

MEMORIAL HOSPITAL

132 POTOMAC STREET

FEBRUARY 1

HALONE

LYNN

SHELL

7-29-1962

FEMALE WHITE

CUMBERLAND, MD.

BOB JEAN RAYNE

HAROLD W. MALONE

200 GREENE ST. CUMBERLAND, MD.

DR. ROBERT D. BROOK J.

1962

CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND-STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND DR. W.F. WILLIAMS												01588	
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LONA CONING</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						d. STREET ADDRESS <b>60 MAIN STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CECELIA</b>		First		Middle		Last		4. DATE OF DEATH <b>FEBRUARY 2 1966</b>		Month Day Year			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-13-1879</b>		9. AGE (In years) <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Business Woman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Lonaconing, MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JAMES MARQUIS</b>						14. MOTHER'S MAIDEN NAME <b>CECELIA PRENTICE</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced Arterio Sclerotic C.V. Sys.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>About 10 days</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>2-1-</b> , 19 <b>66</b> to <b>2-3-</b> , 19 <b>66</b> , that (I) <del>was</del> last saw the deceased alive on <b>2-1-</b> 19 <b>66</b> , and that death occurred at <b>2:12 A.M.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>W.F. Williams</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-2-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>W.F. Williams</b>						22d. ADDRESS <b>Cumberland, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/4/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Lonaconing, MD.</b>					
24. FUNERAL DIRECTOR <b>GEORGE EICHHORN</b>				ADDRESS <b>LONA CONING, MD.</b>				25a. REG'D BY REGISTRAR <b>FEB 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

01584

ALLEGANY

MARYLAND

LOACONING

DAY

A LEGION

CHURCH

MEMORIAL HOSPITAL

DECEASED

MARQUIS

FEBRUARY 2

66

FEMALE WHITE

6-12-1878

66

James Marquis

DECEASED

MEMORIAL HOSPITAL - CHURCH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01642

## CERTIFICATE OF DEATH

01589

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>14 Fourth Street</b>				d. STREET ADDRESS <b>14 Fourth Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A.</b> Last <b>Mattingly</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>3</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1900</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Magnolia, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles Gurtler</b>				14. MOTHER'S MAIDEN NAME <b>Emma Twigg</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Mr. John J. Mattingly, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma</b> <b>1810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Originating in Bladder and spreading</b> DUE TO (c) <b>over the years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>23 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 16</b> , 19 <b>65</b> , to <b>Jan 29</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Jan 29</b> , 19 <b>66</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Carlton Brinsfield</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 4, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Carlton Brinsfield, M.D.</b>				22d. ADDRESS <b>401 Decatur Street, Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 7, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Glenn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Greenspring, W. Va.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01500

01500

01500



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01643

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01590

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LaVale,</i>		c. LENGTH OF STAY IN 1b <i>01-1</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LaVale,</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>35 Rye St.</i>		d. STREET ADDRESS <i>35 Rye St.</i>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Anna</i> Last <i>McDonald</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>6</i> Year <i>19 66</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 9, 1872</i>	9. AGE (In years last birthday) <i>93</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Okonoko, W. Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>G. Tobias Stickley</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Kerns</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Charles A. McTaggart</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <i>CHRONIC MYOCAARDITIS</i> <i>CORONARY HEART DISEASE</i> <i>ARTERIOSCLEROSIS</i>		INTERVAL BETWEEN ONSET AND DEATH <i>YEARS</i> <i>YEARS</i> <i>YEARS</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>FEBRUARY 6, 1966</i>	
EXAMINER'S NAME (Type) <i>BENEDICT SKITARELIC, M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <i>CUMBERLAND, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/8/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Ashby Cemetery</i>	
23d. LOCATION (City, town or county) (State) <i>Fort Ashby, W. Va.</i>					
24. FUNERAL DIRECTOR <i>H. Wayne George</i>		ADDRESS <i>Cumberland, Maryland</i>		25a. REC'D BY REGISTRAR <i>FEB 8 1966</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

042110

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01644

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01591

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hosp.</u>		d. STREET ADDRESS <u>Meadow Brook Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Frank</u> Last <u>McHenry</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11, 1894</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>County Farm Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Allen McHenry</u>		14. MOTHER'S MAIDEN NAME <u>Julia Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Daisy R. McHenry</u>		Address <u>Cresaptown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>----</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		22. DATE SIGNED <u>February 2, 1966</u>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/5/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	
25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>	

11531

RECORD OF DEATH

01514

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EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01645

01592

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN ID <b>5 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Andrew Michael</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 5, 1901</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months <b>64</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter for Growden Constct Company</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cherry Run, West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Michael</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Stewart (Deceased)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-1146</b>	
17. INFORMANT <b>Mrs. Vallie Michael</b>		Address <b>Route #2 Cumberland, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMOTHORAX, BILATERAL</b> <b>9125</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CRUSHED CHEST</b> DUE TO (c) <b>4 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FARM TRACTOR UPSET--PINNING HIM UNDER</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:30 p.m. Jan. 29 1966</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Michael Road Rural Cumberland, Alleg. Md.</b>		20f. (City or town) (County) (State) <b>Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>February 2, 1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/4/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland 21502</b>	
25a. REC'D BY REGISTRAR <b>FEB 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01810

01810

Chas. H. Turner



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may event, within 72 hours after death.

VR A15 (4)  
20M 1/65

01646

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01593

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>19 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>RT. #1, BOX 166</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLYDE</b>		Middle <b>W.</b>		Last <b>MILLER</b>		4. DATE OF DEATH Month <b>FEB.</b>		Day <b>21</b>		Year <b>19 66</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 23, 1905</b>		9. AGE (in years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bowling Alley employee</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>BERLIN, PA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANKLIN MILLER</b>						14. MOTHER'S MAIDEN NAME <b>SUSAN MILLER</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214-05-9586</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Congestive Heart Failure</b> DUE TO (c) <b>Rheumatic &amp; Arteriosclerotic Heart Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>19 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>6/18/57</b> , <b>15:00 to P.M. 3/21, 1966</b> , that (I) (we) last saw the deceased alive on <b>2-21</b> <b>1966</b> , and that death occurred at <b>_____</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>William P. James</b>										22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM P. JAMES</b>						22d. ADDRESS <b>441 N. CENTRE ST. CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Feb. 25, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hyndman</b>		23d. LOCATION (City, town or county) (State) <b>Hyndman, Pa.</b>			
24. FUNERAL DIRECTOR <b>Harvey H. Zeigler</b>						ADDRESS <b>Hyndman, Pa.</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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ALLEGANY

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CUNEBLAND

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MILLER

CLYDE

JULY 23, 1902

MALE WHITE

BERLIN, PA.

FRANKLIN MILLER

MEMORIAL HOSPITAL

11-508

DR. WILLIAM T. JAMES

11-508

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01647

01594

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>Hours</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>ELLERSLIE</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>OSCAR MILLER</b>				4. DATE OF DEATH Month Day Year <b>FEBRUARY 11 1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 20, 1889</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Joshua Miller</b>			
14. MOTHER'S MAIDEN NAME <b>Cornelia Bowers</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO <b>Chr. A.S.H.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Chr. Arteriosclerotic Heart Disease</b> (b) <b>10 yrs.</b> (c) <b>1 yr.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>028.2 Latent Syphilis</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1-19 1966</b> to <b>Feb 11 1966</b> , that (I) (we) last saw the deceased alive on <b>1-19 1966</b> , and that death occurred at <b>5:05 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John A. Topper</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. JOHN TOPPER</b>				22d. ADDRESS <b>HYNDMAN, PA.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/15/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Somerset Penna</b>	
24. FUNERAL DIRECTOR <b>Ruth E. Silcox Cumberland, Maryland 21502</b>				25a. REC'D BY REGISTRAR <b>Feb 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

01648

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01595

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE W. Va.		b. COUNTY Mineral							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 408 N. Centre St.						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ridgeley				d. STREET ADDRESS Carpenter addition		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ida		First Ida		Middle V.		Last Morrissey		4. DATE OF DEATH Feb. 15 1966		Month Feb.		Day 15		Year 1966	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 18, 1998		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Allegany Md.				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Conrad Wagner						14. MOTHER'S MAIDEN NAME Anna (Wilt) Wagner									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Ray Morrissey				Address Ridgeley, Carpenter Addition, W. Va.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 6 - 9, 1955 to 2 - 15, 1966, that (I) (we) last saw the deceased alive on 2 - 15, 1966, and that death occurred at 1a M, from the causes and on the date stated above.															
22a. SIGNATURE Ralph W. Ballin						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-16-66					
22c. PHYSICIAN'S NAME (Type) Ralph W. Ballin M.D.						22d. ADDRESS 62 Greene St. Cumberland, Md. 21502									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 17, 1966		23c. NAME OF CEMETERY OR CREMATORY Hill crest Burial Park				23d. LOCATION (City, town or county) (State) Cumberland Md.							
24. FUNERAL DIRECTOR Byron Knight						ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE FEB 18 1966		25b. REGISTRAR'S SIGNATURE f Charles Judge					

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FOR STATE  
HEALTH DEPT

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01649

01596

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>DOA SACRED HEART HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CORRIGANVILLE</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>H.</b> Last <b>MYERS</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 8, 1890</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCERER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALBERT MYERS</b>		14. MOTHER'S MAIDEN NAME <b>ISABELLE MOORE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>214 01 7849</b>	
17. INFORMANT <b>SYLVIA B. MYERS, CORRIGANVILLE, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying causal last. (b) <b>CORONARY SCLEROSIS</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		22. DATE SIGNED <b>FEB. 11, 1966</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC M.D.</b>		CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>FEB. 14, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ECKHART CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>ECKHART, MD.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>		ADDRESS <b>CUMBERLAND, MD.</b>	
25a. REC'D BY REGISTRAR <b>FEB 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01650						01597					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <b>ALLEGANY</b>						a. STATE <b>MARYLAND</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>						b. COUNTY <b>ALLEGANY</b>					
c. LENGTH OF STAY IN 1b <b>7 HRS.</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						d. STREET ADDRESS <b>320 FURNACE ST.</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>PAUL C. NEHRING</b>			First Middle Last			4. DATE OF DEATH <b>FEBRUARY 1 1966</b>			Month Day Year		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-29-1893</b>		9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Maintenance</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Brewing Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM NEHRING</b>						14. MOTHER'S MAIDEN NAME <b>THERESA ROMAN (Rohman)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214054831</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>					
Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Pulmonary Embolism</i> 4221 DUE TO (b) <i>Coronary Artery Disease</i> DUE TO (c) <i>Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>no</i>											
INTERVAL BETWEEN ONSET AND DEATH <i>hours</i> <i>year</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> , 19 <b>Jan</b> , 1966, that (I) <del>two</del> last saw the deceased alive on <b>Jan 31</b> 19 <b>66</b> , and that death occurred at <b>1:55 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <i>[Signature]</i>						22b. DATE SIGNED <b>2/3/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>DR. O. G. HIMMELWRIGHT</b>						22d. ADDRESS <b>133 VIRGINIA AVE.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Feb. 4, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 8 1966</b>					
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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ALLEGANY

MARYLAND

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CUMBERLAND

7 HRS.

CUMBERLAND

330 PINEAPPLE ST.

MEMORIAL HOSPITAL

FEBRUARY 1 1960

WEHNING

C.

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PAUL

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0-22-1893

WHITE

MALE

U. S. A.

MARYLAND

THERESA ROYAL

WILLIAM WEHNING

MEMORIAL HOSPITAL, CUMBERLAND, MD.

133 VIRGINIA AVE.

DR. D. E. HILFELRIGHT

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM (5)  
5M 1/65

01651

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01598

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D. O. A. Sacred Heart Hospital</b>				d. STREET ADDRESS <b>Rt. 3, Bedford Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Elmer</b> Last <b>O'Donnell</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>9</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1889</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Celanese</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas O'Donnell</b>				14. MOTHER'S MAIDEN NAME <b>Genevieve Carroll</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes War I</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Gertrude Snyder, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>--</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. <b>Dr. Benedict Skitarelic, M.D.</b>		22. DATE SIGNED <b>2-9-1966</b>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic</b>		Address (Street, city, town, or county) <b>Rt. 9 Cumberland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 12, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01508

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*[Handwritten signature]*

3/1/78



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01652 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01599

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN ID <b>Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>427 Columbia Street</b>		d. STREET ADDRESS <b>427 Columbia Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>Elmer</b> Last <b>O'Neal</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 7, 1908</b>
9. AGE (in years last birthday) <b>57 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George O'Neal</b>		14. MOTHER'S MAIDEN NAME <b>Mrs. Ida Bucy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-2640</b>	
17. INFORMANT <b>George O'Neal, Route 2, Hazen Rd., Cumberland Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>4201</b> CORONARY OCCLUSION CORONARY SCLEROSIS DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> --	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		22. DATE SIGNED <b>February 1, 1966</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 4, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove Meth. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Pike-Near Cumberland Md</b>	
24. FUNERAL DIRECTOR <b>John J. Hafer</b>		25a. REC'D BY REGISTRAR <b>FEB 4 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Hafer</b>		25c. REGISTRAR'S SIGNATURE <b>John J. Hafer</b>	

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MEMORANDUM FOR THE RECORD

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Allegany

Allegany

Allegany

Chamberlain

Chamberlain

Chamberlain

127 Columbia Street

127 Columbia Street

February

O'Neal

Allegany

Allegany

27

March 7, 1908

White

White

1908

Allegany

Allegany

Mr. Ida May

George O'Neal

230-10-240 George O'Neal, Route 2, Box 4, Chamberlain

to

CHAMBERLAIN, ALLEGANY

*Chamberlain*

February 1, 1908

RECEIVED ALLEGANY, N.Y.

Feb. 1, 1908. Allegany (now 127). Gen. William H. Chamberlain

230 Balto Ave., Chamberlain, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01653					01600				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY					a. STATE				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					b. COUNTY				
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM?					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
5. SEX					6. COLOR OR RACE				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH				
9. AGE (In years last birthday)					IF UNDER 1 YEAR				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
17. INFORMANT					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 151X DUE TO <u>Ca of stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca of stomach</u> DUE TO (c) <u>Ca of stomach</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>2/1/65</u> , 19 <u>65</u> , to <u>2/24/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/12/66</u> , 19 <u>66</u> , and that death occurred at <u>10</u> A.M., from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City, town or county) (State)				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR				
25b. REGISTRAR'S SIGNATURE					DATE				

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James H. White

James H. White

James H. White

James H. White

James H. White

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>01654</b>						<b>01601</b>					
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>						c. LENGTH OF STAY IN 1b <b>1/23/1962</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Elizabeth W. Patterson</b>						<b>4. DATE OF DEATH</b> <b>February 16, 1966</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>12/11/1875</b>		<b>9. AGE (in years last birthday)</b> <b>90</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Flintstone, Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Thornton Wilson</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Susannah Twigg</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>P.O. Box 599, Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, chr. degenerative &amp; 443X</b> DUE TO <b>decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis &amp; Hypertension</b> DUE TO (c) <b>Marked cerebral deterioration</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1/23/62</b> , 19__, <b>to</b> <b>2/16/66</b> , 19__, <b>that (I) (we) last saw the deceased alive on</b> <b>2/15/66</b> 19__, <b>and that death occurred at</b> <b>A.M.</b> , <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <b>Lee B. Mathews, M. D.</b>						<b>22b. DATE SIGNED</b> <b>2/16/1966</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b>						<b>22d. ADDRESS</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>						<b>23b. DATE THEREOF</b> <b>2/18/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rosehill Cemetery</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Cumberland Maryland</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Ruth E. Silcox</b>						<b>25a. REC'D BY REGISTRAR</b> <b>FEB 21 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

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1/23/1962

1/23/1962

230 N. Lee Street

Allegory County, Illinois

Allegory County, Illinois

Allegory County, Illinois

12/1/1962

12/1/1962

Allegory County, Illinois

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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01602

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
c. LENGTH OF STAY IN 1b <b>32 years</b>		d. STREET ADDRESS <b>1010 Ella Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Industrial Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>Richard</b> Last <b>Poole</b>	4. DATE OF DEATH Month <b>Feb.</b> Day <b>9</b> Year <b>1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1934</b>
9. AGE (In years last birthday) <b>31 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Car Wash</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Graham E. Poole</b>		14. MOTHER'S MAIDEN NAME <b>Ruth E. Card</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Florence Elliott, Bedford Valley</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Skull Fracture; Fracture of Neck</b> <b>8124</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>(Struck by Auto)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by auto (Pedestrian)</b>	
20c. TIME OF INJURY Month, Day, Year <b>7:10 p.m. Feb. 9, 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Industrial Blvd. Cumberland, Md. Alleg.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>February 9, 1966</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 13, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01656

01603

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>		d. STREET ADDRESS <b>RFD#2, Box 138</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>W.</b> Last <b>Porter</b>		4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/17/1879</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church Janitor</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Eckhart, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William Porter</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Matthews</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>213-09-6475</b>		17. INFORMANT <b>P.O. Box 599, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension, ch. degeneration</b> <b>4221</b> DUE TO <b>Stroke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis</b> DUE TO (c) <b>Bilateral Cataracts</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/6/1966</b> , 19 <b>66</b> , to <b>2/24/1966</b> , that (I) (we) last saw the deceased alive on <b>2/23/1966</b> , and that death occurred at <b>A. M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee B. Mathews</b>		22b. DATE SIGNED <b>2/24/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M. D.</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 27, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Eckhart, Maryland</b>
24. FUNERAL DIRECTOR <b>John J. Hafer</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Allegany

Maryland

Allegany

Comberland

1/2/1966

RD#2, Box 138

Allegany County Jail

February 24, 1966

Letter

Letter

16

1/1/1966

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1/1/1966

U. S. A.

Thomas L. Lister, Maryland

Notified: Lister

Barth Matthews

Willard Lister

P.O. Box 299

213-09-6175 Allegany County Jail records

2/2/1966

1/1/1966

2/23/1966

as 6:10 A. M.

X X X 2/2/1966

42 Avenue St., Comberland, Md.

Joe H. Matthews, M. D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01657

01604

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>12/27/1961</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Parthenia</b> Last <b>Reed</b>		4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/1/1889</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Emma Kirtley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>B.O. Box 599</b>		Address <b>Cumberland, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> DUE TO (b) <b>(2) Arterio Sclerosis, General</b> DUE TO (c) <b>(3) Diabetes mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/27/61</b> , 19__, to <b>2/6/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>2/5/66</b> , 19__, and that death occurred at <b>A.</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee B. Mathews, M.D.</b>		22b. DATE SIGNED <b>2/7/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M. D.</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 8, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Near Cumberland, Md</b>	
24. FUNERAL DIRECTOR <b>John J. Zuber</b>		25a. REC'D BY REGISTRAR <b>FEB 9 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>230 Baltimore Ave., Cumberland, Md</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01605

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Riordan Rd.</b>		d. STREET ADDRESS <b>Riordan Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Doris</b> First <b>Adeline</b> Middle <b>Rigglesman</b> Last		4. DATE OF DEATH <b>Feb.</b> Month <b>16</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1902</b>
9. AGE (In years lost birthday) yrs. <b>64</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Allegany-Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Metz</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Lashbaugh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Alonzo Rigglesman - Westernport, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Ventricular fibrillation</b> DUE TO (b) <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 12, 1965</b> , to <b>2/16, 1966</b> that (I) (we) last saw the deceased alive on <b>Feb. 10, 1966</b> , and that death occurred at <b>4:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Phillip G. Staggors</b>		22b. DATE SIGNED <b>2/17/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Phillip G. Staggors</b>		22d. ADDRESS <b>Keyser, W. Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/19.1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		23d. LOCATION (City or Town) (County) (State) <b>Westernport Md.</b>	
24. FUNERAL DIRECTOR <b>E. B. Buel</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 21 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Westborough

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

<div>Item 8. Form 383 - 11/3/66</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>01659</div> <div>01606</div>									
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>West Va.</b> b. COUNTY <b>Grant</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>21 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Petersburg</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>			First Middle Last <b>RIGGLEMAN</b>			4. DATE OF DEATH <b>February 9 19 66</b>		Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug-5-1894</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife -</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hardy County -</b>		12. CITIZEN OF WHAT COUNTRY? <b>U-S-A -</b>		
13. FATHER'S NAME <b>Glason Simmons</b>					14. MOTHER'S MAIDEN NAME <b>Magdelene Pratt</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Memorial Hospital--Cumberland, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangrene of Bowell</b> <b>4501</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mesenteric Thrombosis</b> (c) <b>Arteriosclerosis</b>									INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b> <b>4 days</b> <b>----</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of left hip</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Fell at home</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9:30 a.m. Jan 19 66</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Petersburg, Grant, W. Va.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>February 9, 1966</b> Address (Street, city, town, or county) <b>CUMBERLAND, MD.</b>						
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>			22. DATE SIGNED						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried -</b>			23b. DATE THEREOF <b>2/2/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New House Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Riz - W. Va.</b>		
24. FUNERAL DIRECTOR <b>Byron Light - Cumberland Md.</b>					ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 21 1966</b>		
							25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

01655

01600

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Allegany

West Va.

Grant

Chamberland

21 days

Chamberland

Memorial Hospital

JOHN

MEMORIAL

MEMORIAL

88

White

77

Chamberland of Howell

1 days

1 days

Memorial Hospital

Arteriosclerosis

X

Polli at home

2:30 -- Jan 19 68

home

Memorial Hospital, Grant, W. Va.

February 9, 1968

MEMORIAL HOSPITAL, N.H.

FEB 21 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, only completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please to move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GRANTSVILLE</b>		11-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>RT. 2 BOX 100</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>E</b> Last <b>RODEHEAVER</b>		4. DATE OF DEATH Month <b>2</b> Day <b>16</b> Year <b>66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-30-1900</b>
9. AGE (In years last birthday) yrs. <b>65</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>GARRETT MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ALLEN RODEHEAVER</b>		14. MOTHER'S MAIDEN NAME <b>MARGUERITE BITTINGER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>SELF</b>		Address <b>RT. 2 GRANTSVILLE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYELOGENOUS LEUKEMIA</b> <b>2043</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 mon</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-11</b> , 19 <b>66</b> , to <b>2-16</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>2-16</b> , 19 <b>66</b> , and that death occurred at <b>5 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W.C. Spiggle</b>		22b. DATE SIGNED <b>2/17/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. C. Spiggle, MD.</b>		22d. ADDRESS <b>126 N. Smallwood St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/18/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bittinger Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bittinger, Garrett, Md.</b>	
24. FUNERAL DIRECTOR <b>Don J. Newman, Grantsville Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

01607

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PATIENT'S NAME		PATIENT'S ADDRESS	
PATIENT'S PHONE		PATIENT'S DATE OF BIRTH	
PATIENT'S SEX		PATIENT'S RACE	
PATIENT'S RELIGION		PATIENT'S OCCUPATION	
PATIENT'S MARITAL STATUS		PATIENT'S EDUCATION	
PATIENT'S PRESENT ILLNESS		PATIENT'S HISTORY	
PATIENT'S PHYSICAL EXAMINATION		PATIENT'S LABORATORY TESTS	
PATIENT'S TREATMENT		PATIENT'S PROGNOSIS	
PATIENT'S DISCHARGE		PATIENT'S FOLLOW-UP	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

M

01661

01608

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>	
c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		d. STREET ADDRESS <b>260 E MAIN ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MR. JOHN A RUGE</b>		4. DATE OF DEATH Month Day Year <b>FEB 23 24, 19 66</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/5/97</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL MINES</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ECKHART, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>ROBERT J. RUGE</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES SCHREIBER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-09-6511</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Conc. intracranial pressure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>multiple brain abscess</b> DUE TO (c) <b>probably metastatic carcinoma of middle ear cavity</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 10:30 AM from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. V. Valls</b>		22b. DATE SIGNED <b>FEB. 28, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. V. VALLS</b>		22d. ADDRESS <b>113A S. CENTRE ST. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>FEB. 28 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>MAR 3 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

11/25/57

11/25/57

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01662					01609				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>51 DAYS</b>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LONA CONING, MD.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>18 JACKSON ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLINTON B. RUSSELL</b>			4. DATE OF DEATH Month <b>FEB.</b> Day <b>16</b> Year <b>19 66</b>						
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 21, 1891</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months <b>7</b>	IF UNDER 24 HRS. Days <b>1</b>	Hours <b>19</b>	Min. <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM RUSSELL</b>				14. MOTHER'S MAIDEN NAME <b>JANET HERON</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes War # 1</b>			16. SOCIAL SECURITY NO. <b>216-05-2956</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>578X</b> <i>Overwhelming toxemia due to</i> DUE TO (b) <i>Multiple ulcerations of sigmoid colon</i> DUE TO (c) <i>Acute cholecystitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypostatic pneumonia - both lungs</i>									INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>1 1/2 months</i> <i>1 month</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>12/27/65</b> <b>8:37 P.M.</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>2/16</b> 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Thomas F. Lewis</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/17/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>DR. THOMAS F. LEWIS</b>					22d. ADDRESS <b>500 GREENE ST. CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/19/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Lonaconing, MD.</b>		
24. FUNERAL DIRECTOR <b>GEORGE EICHHORN</b>				ADDRESS <b>Lonaconing, MD.</b>		25a. REC'D BY REGISTRAR <b>FEB 21 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

01600

01600

MARYLAND

MARYLAND

MARYLAND

LONARON INC, MD.

21 DAYS

CUMBERLAND

18 JACKSON ST.

MEMORIAL HOSPITAL

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16

FEB.

RUSSELL

6.

CLINTON

NOV. 21, 1891

MALE WHITE

U.S.A.

MARYLAND

edit ed

JANET HERON

WILLIAM RUSSELL

MEMORIAL HOSPITAL

10-00-1950

FOR

8:37 P.M.

500 GREENE ST. CUMBERLAND, MD.

DR. THOMAS F. LEWIS

JANUARY 1951

JANUARY 1951

JANUARY 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01663					01610				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN ID <b>2 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSP.</b>					d. STREET ADDRESS <b>407 CUMBERLAND ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNA</b>			First <b>M.</b> Middle <b>SALYARDS</b> Last		4. DATE OF DEATH <b>2-6-1966</b>		Month <b>2</b> Day <b>6</b> Year <b>19</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-29-1889</b>		9. AGE (In years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Winchester, Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>David Lewis</b>					14. MOTHER'S MAIDEN NAME <b>Mettie Kirby</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHART &amp; DAUGHTER</b>			Address <b>SAME ADDRESS</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized Carcinomatosis, Diabetes mellitus</b>									INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4 Feb</b> , 19 <b>66</b> , to <b>6 Feb</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>6 Feb.</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>James G. Stegmaier</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7 Feb 66</b>		
22c. PHYSICIAN'S NAME (Type) <b>James G. Stegmaier, M.D.</b>					22d. ADDRESS <b>122 S. Centre St., Cumberland, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>		
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>FEB 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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ALLIANCE

1-3-1962

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FEMALE

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SAME ADDRESS

CHART CHAUGHTER

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
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01664

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01611

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Little Orleans</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <b>Little Orleans</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>P.</b> Last <b>Shipley</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 16, 1875</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>01</b> Days <b>1</b> Hours <b>01</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Samuel Shipley</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Potts</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-46-2827</b>	
17. INFORMANT <b>Olney Whitfield</b>		Address <b>Little Orleans, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>---</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>		22. DATE SIGNED <b>February 8, 1966</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>February 8, 1966</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 10, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Christian Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Artemas, Penna.</b>	
24. FUNERAL DIRECTOR <b>John J. Hafer</b>		ADDRESS <b>230 Baltimore Ave., Cumberland</b>	
25a. REC'D BY REGISTRAR <b>Feb 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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William

Alfred

Little Graham

John

Little Graham

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February

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February

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April 10, 1968

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White

Male

Married

Self employed

Parent

Harvey Foster

Samuel Shipley

01

Other Address

220-44-3827

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Germany Occupation

Germany Occupation

X

X

X

February 8, 1968  
Cambridge, MA

BENEDICT BENTLEY, M.D.

Feb. 10, 1968  
Cambridge, MA

320 Cambridge Ave., Cambridge, MA

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01665

01612

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> <span style="float: right;"><b>30 YEARS</b></span> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>131 Washington Street</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>ALLEGANY</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> d. STREET ADDRESS <b>131 Washington Street</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>MABEL VIRGINIA SIGLER</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>FEBRUARY 10, 1966</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>OCTOBER 26, 1915</b>		<b>9. AGE</b> (In years last birthday) <b>50</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>ALTOONA, PENNA.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>JAMES GATES</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>LEORA CRITCHFIELD</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>			
<b>17. INFORMANT</b> <b>MR. EVAN SIGLER, 131 WASHINGTON ST.</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Liver failure</b> DUE TO (b) <b>Metastatic carcinoma from</b> DUE TO (c) <b>right breast</b>		INTERVAL BETWEEN ONSET AND DEATH <b>one month</b> <b>1 1/2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>July 20, 1964</b> , to <b>Feb 10, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 5, 1966</b> , and that death occurred at <b>11/11/66</b> M, from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <b>Thomas F. Lewis, M.D.</b>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>2/11/66</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>THOMAS F. LEWIS, M.D.</b>		<b>22d. ADDRESS</b> <b>500 GREENE ST., CUMBERLAND, MD.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>FEB. 13, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>SUNSET MEMORIAL PARK</b>			
<b>23d. LOCATION</b> (City, town or county) (State) <b>CUMBERLAND MD.</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HAFFER FUNERAL HOME, 30 W. MAIN ST.</b>					
<b>25a. REC'D BY REGISTRAR</b> <b>FEB 16 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please place the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01666					01613				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)				
a. COUNTY <b>Allegany</b>					a. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>					b. COUNTY <b>Allegany</b>				
c. LENGTH OF STAY IN 1b <b>64 Years</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3 Evergreen Terrace</b>					d. STREET ADDRESS <b>3 Evergreen Terrace</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Thomas E Simon</b>					4. DATE OF DEATH <b>February 20 1966</b>				
5. SEX <b>Male</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH <b>Dec. 29 1901</b>				
9. AGE (In years last birthday) <b>64 yrs.</b>					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>William Simon</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Norton</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>70</b>				
17. INFORMANT <b>Hellen Simon</b>					Address <b>3 Evergreen Terrace</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Diabetes mellitus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>4 yrs.</b> <b>3 yrs.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>None 19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 26, 1962</b> , to <b>Feb. 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb. 20, 1966</b> , and that death occurred at <b>9.20 AM, PM</b> on the causes and on the date stated above.									
22a. SIGNATURE <b>James P. Hallinan M.D.</b>					22b. DATE SIGNED <b>2-22-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>James P. Hallinan M.D.</b>					22d. ADDRESS <b>140 Bedford St. Cumberland, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>Feb. 23, 1966</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul</b>					23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>				
24. FUNERAL DIRECTOR <b>Louis Stein Inc.</b>					25a. REC'D BY REGISTRAR <b>FEB 24 1966</b>				
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7-62

MEDICAL CERTIFICATION

<div>1</div> <div>M</div> <div>01663</div> <div>01614</div>											
<div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>ALLEGANY</div> <div>MARYLAND</div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>FROSTBURG</div> <div>c. LENGTH OF STAY IN 1b</div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>MINERS' HOSPITAL</div>											
<div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE</div> <div>MARYLAND</div> <div>b. COUNTY</div> <div>ALLEGANY</div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>R.F.D.1, Box 33, FROSTBURG</div> <div>d. STREET ADDRESS</div> <div>WRIGHTS CROSSING</div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>											
<div>3. NAME OF DECEASED (Type or print)</div> <div>First</div> <div>MARY</div> <div>Middle</div> <div>ELLEN</div> <div>Last</div> <div>SMITH</div> <div>4. DATE OF DEATH</div> <div>Month</div> <div>FEBRUARY</div> <div>Day</div> <div>28</div> <div>Year</div> <div>1966</div>											
<div>5. SEX</div> <div>FEMALE</div> <div>6. COLOR OR RACE</div> <div>WHITE</div> <div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> <div>8. DATE OF BIRTH</div> <div>JANUARY 22, 1903</div> <div>9. AGE (In years last birthday)</div> <div>63 yrs.</div> <div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div> <div>Hours</div> <div>Min.</div>											
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>HOUSEWIFE</div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>OWN HOME</div> <div>11. BIRTHPLACE (County &amp; State, or foreign country)</div> <div>U.S.A.</div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>											
<div>13. FATHER'S NAME</div> <div>PETER MC DONALD</div> <div>14. MOTHER'S MAIDEN NAME</div> <div>SARAH MC GRADY</div>											
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)</div> <div>NO</div> <div>16. SOCIAL SECURITY NO.</div> <div>17. INFORMANT</div> <div>MR. JAMES L. SMITH, R.D.D.1, BOX 33</div> <div>Address</div> <div>FROSTBURG, MD.</div>											
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>4222</div> <div>Bi-lateral pulmonary fibrosis</div> <div>Chronic myocarditis</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>(b)</div> <div>(c)</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>2 years</div> <div>2 years</div>											
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>											
<div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour</div> <div>a.m.</div> <div>p.m.</div> <div>19</div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div>											
<div>21. I certify that (I) (this hospital) attended the deceased from 1-10 1966, to 2-28 1966, that (I) (we) last saw the deceased alive on 2-28 1966, and that death occurred 1:50 PM from the causes and on the date stated above.</div> <div>22a. SIGNATURE</div> <div>H.C. Diehl</div> <div>M.D.</div> <div>ATTENDING PHYS.</div> <div><input checked="" type="checkbox"/></div> <div>MED. DIRECTOR</div> <div><input type="checkbox"/></div> <div>STAFF PHYS.</div> <div><input type="checkbox"/></div> <div>22b. DATE SIGNED</div> <div>3/21/66</div> <div>22c. PHYSICIAN'S NAME (Type)</div> <div>H.C. DIEHL, M.D.</div> <div>22d. ADDRESS</div> <div>39 WEST MAIN STREET, FROSTBURG, MD.</div>											
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div> <div>23b. DATE THEREOF</div> <div>MARCH 3, 1966</div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>ST. MICHAEL'S CEM.</div> <div>23d. LOCATION (City, town or county)</div> <div>FROSTBURG, MARYLAND</div>											
<div>24. FUNERAL DIRECTOR'S SIGNATURE</div> <div>HAFFER FUNERAL HOME, 60 W. MAIN ST.</div> <div>ADDRESS</div> <div>FROSTBURG, MD.</div> <div>25a. REC'D BY REGISTRAR</div> <div>MAR 7 1966</div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>											

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1910

RIGHTS MISSING

RIGHTS MISSING

JANUARY 22, 1903

JANUARY 22, 1903

CARL H. GRAY

CARL H. GRAY

*Handwritten:* The lateral fulcrum follows  
the line of the spine

1-10

1-10

*Handwritten:* The lateral fulcrum follows  
the line of the spine

1-10

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TO NEW YORK CITY, N.Y.

TO NEW YORK CITY, N.Y.

TO NEW YORK CITY, N.Y.

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TO NEW YORK CITY, N.Y.

TO NEW YORK CITY, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01668

CERTIFICATE OF DEATH

01615

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>			c. LENGTH OF STAY IN 1b <u>2 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kyle Nursing Home</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Franklin</u> Last <u>Snyder</u>				4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 8, 1887</u>		
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Green</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>15-63-5786</u>		17. INFORMANT <u>Lionel Clark</u>			
			Address <u>Barton, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Ischemia</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Cr Disease</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>Feb 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 2, 1966</u> , and that death occurred at <u>2 A.M.</u> , from causes and on the date stated above.								
22a. SIGNATURE <u>Leslie R. Miles</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-7-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Leslie R. Miles</u>			22d. ADDRESS <u>Lonaconing, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/9/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Moscow Mills Allegany Md.</u>		
24. FUNERAL DIRECTOR <u>Westerport, Md</u>				25a. REC'D BY REGISTRAR <u>Feb 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

01310

01310

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/10/2001 BY 60322 UCBAW/SJS/STP

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="float: left; width: 15%;">01669</div> <div style="float: right; width: 15%;">01616</div> <div style="clear: both;"></div> <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>DR. R.J. WILLIAMS      CERTIFICATE OF DEATH</b> </div>					
<b>1. PLACE OF DEATH</b> a. COUNTY <div style="font-size: 1.2em;">ALLEGANY</div>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <div style="font-size: 1.2em;">WEST VIRGINIA</div> b. COUNTY <div style="font-size: 1.2em;">MORGAN ✓</div>		
<b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <div style="font-size: 1.2em;">CUMBERLAND</div>		<b>c. LENGTH OF STAY IN IB</b> <div style="font-size: 1.2em;">2 DAYS</div>	<b>c. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <div style="font-size: 1.2em;">PAW PAW</div>		
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) <div style="font-size: 1.2em;">MEMORIAL HOSPITAL</div>			<b>d. STREET ADDRESS</b> <div style="font-size: 1.2em;">85-3</div>		<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <div style="font-size: 1.2em;">RAYMOND H. SNYDER</div>			<b>4. DATE OF DEATH</b> Month Day Year <div style="font-size: 1.2em;">FEBRUARY 9 19 66</div>		
<b>5. SEX</b> <div style="font-size: 1.2em;">MALE</div>	<b>6. COLOR OR RACE</b> <div style="font-size: 1.2em;">WHITE</div>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <div style="font-size: 1.2em;">7-13-1901</div>		<b>9. AGE</b> (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <div style="font-size: 1.2em;">64 yrs.</div> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em;">RETIRED</div>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <div style="font-size: 1.2em;">B. &amp; O. R.R.CO.</div>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <div style="font-size: 1.2em;">OKONOKA, W.VA.</div>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <div style="font-size: 1.2em;">U.S.A.</div>
<b>13. FATHER'S NAME</b> <div style="font-size: 1.2em;">SAMUEL SNYDER</div>			<b>14. MOTHER'S MAIDEN NAME</b> <div style="font-size: 1.2em;">LAURA MALCOLM</div>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <div style="font-size: 1.2em;">No</div>		<b>16. SOCIAL SECURITY NO.</b> <div style="font-size: 1.2em;">705-05-9263</div>		<b>17. INFORMANT</b> Address <div style="font-size: 1.2em;">MEMORIAL HOSPITAL - CUMBERLAND, MD.</div>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="font-size: 1.2em;">Coronary Thrombosis</div> DUE TO <div style="font-size: 1.2em;">Art &amp; Scler Corp</div> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <div style="font-size: 1.2em;">17 hrs</div>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. _____ 19____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <div style="font-size: 1.2em;">Cumberland City, Md</div>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <div style="font-size: 1.2em;">7/3/60</div> , <b>at</b> <div style="font-size: 1.2em;">4:30</div> <b>to</b> <div style="font-size: 1.2em;">2/9/66</div> , <b>that (I) (we) last saw the deceased alive on</b> <div style="font-size: 1.2em;">2/8/66</div> , <b>and that death occurred at</b> <div style="font-size: 1.2em;">M</div> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <div style="font-size: 1.2em;">[Signature]</div>			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <div style="font-size: 1.2em;">2/10/66</div>
<b>22c. PHYSICIAN'S NAME (Type)</b> <div style="font-size: 1.2em;">DR. R. J. WILLIAMS</div>			<b>22d. ADDRESS</b> <div style="font-size: 1.2em;">122 S. CENTRE ST., CUMBERLAND, MD</div>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <div style="font-size: 1.2em;">Burial</div>		<b>23b. DATE THEREOF</b> <div style="font-size: 1.2em;">2/12/1966</div>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <div style="font-size: 1.2em;">Levels Cemetery</div>		<b>23d. LOCATION</b> (City, town or county) (State) <div style="font-size: 1.2em;">Levels, West Virginia</div>
<b>24. FUNERAL DIRECTOR</b> <div style="font-size: 1.2em;">Johnson Funeral Home Berkeley Spgs. W. Va</div>			<b>25a. REC'D BY REGISTRAR</b> <div style="font-size: 1.2em;">Feb 14 1966</div>		<b>25b. REGISTRAR'S SIGNATURE</b> <div style="font-size: 1.2em;">Charles Judge</div>

01010

MORGAN

WEST VIRGINIA

RAW PAW

2 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

RAYMOND

H.

SNYDER

FEBRUARY 2

SA

7-13-1961

WHITE

DATE

TESTED

SAMUEL SNYDER

B. S. E. R. B. C. O. W. V. A.

LAUREL, W. V.

700-01-2003 MEMORIAL HOSPITAL - CUMBERLAND, MD.

DR. P. J. WILLIAMS

Burial 2/15/66 - Lewis Cemetery

Level, West Virginia

Johnson General Home Berkeley Spgs. W. Va.



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VR A15 (4)  
15M 4-64

1 (M)

01670

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01617

1. PLACE OF DEATH e. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>1/2 HOUR</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS HOSPITAL</b>				d. STREET ADDRESS <b>197 EAST MAIN STREET</b>			
3. NAME OF DECEASED (Type or print) <b>HUGHEY QUENTIN SPIKER</b>		First Middle Last		4. DATE OF DEATH Month Day Year <b>FEBRUARY 26 1966</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 8, 1900</b>	9. AGE (in years last birthday) <b>65 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARBER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN BUSINESS</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ALLEGANY COUNTY</b>			
13. FATHER'S NAME <b>JOSEPH SPIKER</b>				14. MOTHER'S MAIDEN NAME <b>VIRGINIA MOORE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-09-6542</b>		17. INFORMANT <b>MRS. QUENTIN SPIKER, 197 EAST MAIN ST.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Acute Coronary Occlusion &amp; massive myocardial infarction</b> DUE TO (b) <b>myocardial infarction</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/26</b> , 19 <b>66</b> , to <b>2/26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/26</b> , 19 <b>66</b> , and that death occurred at <b>8:40 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Martin M. Rothstein, M.D.</b>				22b. DATE SIGNED <b>2/28/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN, M.D.</b>				22d. ADDRESS <b>48 BROADWAY, FROSTBURG, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MARCH 1, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>HAFFER FUNERAL HOME, 60 WEST MAIN ST.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

07117

07117

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>KEYSER W. Va.</b>						
c. LENGTH OF STAY IN 1b <b>2 DAYS</b>					d. STREET ADDRESS <b>23½ PIEDMONT ST.</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>GEORGE</b>			First <b>RODNEY</b>			Middle <b>THRASHER</b>			Last <b>THRASHER</b>		
4. DATE OF DEATH <b>FEB.</b>			Month <b>2</b>			Day <b>166</b>			Year <b>1966</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 18, 1966</b>		9. AGE (In years last birthday) <b>15</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>				11. BIRTHPLACE (County & State, or foreign country) <b>KEYSER. W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GENE THRASHER</b>						14. MOTHER'S MAIDEN NAME <b>ANNA MARIE KOMATZ</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CNS failure</b> <b>341X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lateral series thrombosis</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/81</b> <b>5:40 P.M. 2/2</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>2/2</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>DR. ROBERT D. BRODELL</b>								22b. DATE SIGNED <b>500 GREENE ST. CUMBERLAND, MD.</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. ROBERT D. BRODELL</b>				22d. ADDRESS <b>500 GREENE ST. CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Feb. 4, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart, Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Eckhart, Md.</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 10 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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WEST VIRGINIA

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KEYSER

2500 RICHMOND ST.

MEMORIAL HOSPITAL

PCB

THR. SHEP

BOULEV

GEORGE

JAN. 18, 1962

MALE WHITE

KEYSER, W.V.

GENE THRASHER

ALMA MARIE KOWATZ

MEMORIAL HOSPITAL

DR. ROBERT D. BRODELL

DR. ROBERT D. BRODELL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01672 CERTIFICATE OF DEATH 01619											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			c. LENGTH OF STAY IN 1b <b>44 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>163 East Main Street</b>					d. STREET ADDRESS <b>163 East Main Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frank</b>			First Middle Last <b>Via</b>		4. DATE OF DEATH <b>Feb. 15 1966</b>		Month Day Year				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>June 14, 1877 88</b>		9. AGE (In years last birthday) <b>88 yrs.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Grocery-Producer</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Celico Cosenza, Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Antonio Via</b>					14. MOTHER'S MAIDEN NAME <b>Rachel Sicoli</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Adolph &amp; Albert Via, Frostburg, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b> <b>1561</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>??</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1, 1966</b> , to <b>Feb 15, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 1, 1966</b> , and that death occurred <b>2:00 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>W O McLane</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb 16 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. W. O. McLane, M.D.</b>					22d. ADDRESS <b>167 E. Main St., Frostburg, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 18, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Frostburg, Md.</b>				
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>FEB 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

BP

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01673

01620

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG,</b>				c. LENGTH OF STAY IN 1b <b>8 WEEKS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WELSH HILL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RT. 1, FROSTBURG,</b>			
				d. STREET ADDRESS <b>01-1</b>			
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>A.</b> Last <b>WALKER</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>14TH</b> Year <b>19 66</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 14th, 1886</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE ADAMS</b>				14. MOTHER'S MAIDEN NAME <b>EDITH GRIFFITH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>220-10-9346</b>		17. INFORMANT <b>MRS. RAYMOND MONAHAN, FROSTBURG, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Rectum</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1, 1965</b> , to <b>FEB 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>FEB 1, 1966</b> , and that death occurred at <b>8 A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>W O McLane</b>				22b. DATE SIGNED <b>Dec 15 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>W. O. McLANE,</b>	
				22d. ADDRESS <b>167 E. MAIN ST., FROSTBURG, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-16-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F'BG. MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR.,</b>				25a. REC'D BY REGISTRAR <b>FEB 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	
				ADDRESS <b>FROSTBURG, MD.</b>			

01080

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01674											
01621											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>40 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>721 Glenmore Street</b>					d. STREET ADDRESS <b>721 Glenmore St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Jesse</b>		Middle <b>Harold</b>		Last <b>Weaver</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>4</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 14, 1904 61</b>		9. AGE (In years last birthday) <b>61</b> yrs. IF UNDER 1 YEAR: Months <b>01</b> Days <b>1</b> IF UNDER 24 HRS.: Hours <b>00</b> Min. <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>B&amp;O Engineer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Thomas W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>George Weaver</b>					14. MOTHER'S MAIDEN NAME <b>Alice Gross</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Clara Weaver, Cumberland, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO (b) <b>Right Hemiplegia</b> DUE TO (c) <b>Hypertension</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b> <b>2 yrs</b> <b>2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1, 1965</b> , to <b>Feb 4, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 3, 1966</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Clay E. Durrett</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 4, 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. Clay E. Durrett, M.D.</b>					22d. ADDRESS <b>236 Virginia Ave., Cumberland, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Feb. 7, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>				
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>Feb 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

45310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01675		Item #8 Film #G373 2/14/66		01622							
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>11 HRS.</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MT. SAVAGE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>Calla Hill</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>GERTRUDE</b>		First <b>REGINA</b>		Middle <b>WERNER</b>		Last <b>WERNER</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>1966</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-15-1889</b>		9. AGE (in years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Church Rectory</b>				11. BIRTHPLACE (County & State, or foreign country) <b>PA. Pocahontas</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Harmon Baer</b>				14. MOTHER'S MAIDEN NAME <b>Anna Loraditch</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-16-2269</b>				17. INFORMANT <b>PATIENT'S CHART</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Posterior Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease with chronic congestive failure and several old myocardial infarctions.</b> DUE TO (c) <b>myocardial infarctions.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>February 1, 1966</b> , to <b>February 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>February 1, 1966</b> , and that death occurred at <b>12:55</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Wyand F. Doerner, Jr., M.D.</b>				22b. DATE SIGNED <b>2-2-66</b>							
22c. PHYSICIAN'S NAME (Type) <b>Wyand F. Doerner, Jr., M.D.</b>				22d. ADDRESS <b>414 N. Mechanic St., Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2/5/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>			
23d. LOCATION (City, town or county) (State) <b>Mount Savage, Maryland</b>				24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>				25a. REC'D BY REGISTRAR <b>Feb 8 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01676

CERTIFICATE OF DEATH

01623

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>5 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland Bowling Green</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>12 Poplar St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Lewis</b> Last <b>Wheeler</b>				4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-11-93</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>W. Va. Williamsport, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wesley Wheeler</b>				14. MOTHER'S MAIDEN NAME <b>Annie Taylor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>705-10-7953</b>		17. INFORMANT <b>Mrs. Hazel Wheeler</b> Address <b>Bowling Greene 12 Poplar St.</b> <b>Patient's chart</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> <b>157x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma head of the Pancreas</b> DUE TO <b>C metastases to Liver.</b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-4</b> , 19 <b>66</b> , to <b>2-9</b> , 1966, that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b></b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>William Roger Wolverton</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-11-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>William Roger Wolverton MD</b>				22d. ADDRESS <b>108 HA PRISON ST CUMBERLAND MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>2/12/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>C Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 14 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

01628

INVESTIGATION OF DEATH

01628

NAME OF DECEASED		DATE OF DEATH	
LAST NAME, FIRST NAME, MIDDLE NAME		MM/DD/YYYY	
AGE		SEX	
DATE OF BIRTH		PLACE OF BIRTH	
OCCUPATION		EDUCATION	
MARITAL STATUS		RELIGION	
MANNER OF DEATH		CAUSE OF DEATH	
PLACE OF DEATH		DATE OF DEATH	
TIME OF DEATH		WITNESSES	
FAMILY HISTORY		SOCIAL HISTORY	
MEDICAL HISTORY		PSYCHOLOGICAL HISTORY	
SUBSTANCE ABUSE HISTORY		OTHER RELEVANT INFORMATION	

CO. EVERY BUSINESS DAY. THE FOLLOWING INFORMATION IS FOR THE USE OF THE FBI AND IS NOT TO BE RELEASED TO THE PUBLIC WITHOUT THE WRITTEN CONSENT OF THE FBI.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01673

01624

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Sampson Zeller</u>		4. DATE OF DEATH Month Day Year <u>Feb. 27, 1966</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/1/1880</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Barber</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>	
13. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>Gustave Zeller</u>		16. MOTHER'S MAIDEN NAME <u>Maretta Workman</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO. <u>Robert Zeller, Cleveland, Ohio</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERITONITIS - TERMINAL</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC CARCINOMA - (INTESTINAL)</u> DUE TO (c) <u>CARCINOMA OF THE PROSTATE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 HRS</u> <u>4 YRS.</u> <u>4 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>✓</u>	
20c. TIME OF INJURY Hour a. m. p. m. <u>✓</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>✓</u>		20f. (City or town) (County) (State) <u>✓</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/24, 1966</u> , to <u>2/27, 1966</u> , that (I) (we) last saw the deceased alive on <u>2/27, 1966</u> , and that death occurred at <u>6:15 P. M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Martin M. Rothstein M.D.</u>		22b. DATE SIGNED <u>2/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARTIN M. ROTHSTEIN M.D.</u>		22d. ADDRESS <u>48 BROADWAY - FROSTBURG - MD. 2153</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/2/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Park</u>		23d. LOCATION (City, town, or county) (State) <u>Frostburg, Allegany, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Grantsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01684

CERTIFICATE OF DEATH

01684